PROPOSED RULEMAKING

STATE BOARD OF COSMETOLOGY

[49 PA. CODE CH. 7]

Practice of Massage Therapy in Cosmetology or Esthetician Salons

The State Board of Cosmetology (Board) proposes to add § 7.150 (relating to practice of massage therapy in cosmetology or esthetician salons) to read as set forth in Annex A.

Effective Date

This proposed rulemaking will be effective upon publication of final-form rulemaking in the *Pennsylvania Bulletin*.

Statutory Authority

The act of September 24, 2014 (P.L. 2476, No. 136) amended the act of May 3, 1933 (P.L. 242, No. 86) referred to as the Cosmetology Law (act) (63 P.S. §§ 507—527), by adding section 9.3 to the act (63 P.S. § 515.3) allowing for the practice of massage therapy within the licensed square footage of a cosmetology or esthetician salon. Section 9.3(d) of the act requires the Board and the State Board of Massage Therapy to jointly promulgate final regulations to carry out the provisions of section 9.3.

Background and Purpose

Section 9.3(a) of the act permits an individual licensed under the Massage Therapy Law (63 P.S. §§ 627.1—627.50), to practice massage therapy within the approved premises of a licensed cosmetology salon or a licensed esthetician salon if: (1) the massage therapy licensee is the owner of or employed by the salon and is not an independent contractor; (2) the massage therapist practices in accordance with the act and the Massage Therapy Law; and (3) the salon owner provides an appropriate level of privacy for clients. Section 9.3(a)(3)(i) and (ii) of the act further provides that no physical barrier is required when the massage therapist is performing services that a cosmetologist or esthetician could perform; however, should the services exceed those within the scope of cosmetology or esthetics, a separate room with permanent walls and doors must be utilized. Section 9.3(a)(3)(iii) of the act further provides that an esthetician may provide services in the separate room that is designated for massage therapy services, so long as the cosmetologist or esthetician and massage therapist are not providing services concurrently.

Under section 9.3(b) of the act, a licensee is subject to inspection by the Board and the State Board of Massage Therapy. A licensee who violates the act or the Massage Therapy Law shall be subject to discipline by the licensee's applicable licensing board. Section 9.3 of the act immediately permitted the practice of massage therapy within the licensed square footage of a cosmetology or esthetician salon. For the most part, the amendments to the act were self-executing. The purpose of the Board's joint regulations with the State Board of Massage Therapy is to clarify standards for the practice of massage therapy in cosmetology or esthetician salons, but it was not immediately clear what provisions required clarification and amendments to the regulations. The Board and the State Board of Massage Therapy worked together in determining and drafting the joint regulations and received input from regulated communities. The Board and the State Board of Massage Therapy agreed to promulgate regulations to address appropriate levels of privacy while practicing massage therapy and minimum size requirements for the separate massage therapy room.

Prior to the enactment of section 9.3 of the act, a patron wishing to receive services from a massage therapist and an esthetician would have to move from one room (a room considered not to be within the licensed square footage of the salon) to another room (a room considered to be within the licensed square footage of the salon) for each of the requested services. This process was found to be averse to the relaxing environment facilities were attempting to provide for their clients. The purpose of section 9.3 of the act is to allow for the practice of massage therapy within the licensed square footage of a cosmetology or esthetician salon. With the enactment of section 9.3(a)(3)(iii) of the act, a patron can receive massage therapy and esthetic services all within one room. This proposed rulemaking sets forth the requirements for practicing massage therapy in a cosmetology or esthetician salon. The State Board of Massage Therapy is similarly updating its regulations to clarify the standards for massage therapy in its salons and to ensure consistency between the standards of the Board and the State Board of Massage Therapy.

Description of the Proposed Amendments

The Board proposes to add § 7.150 to set forth the standards for practicing massage therapy within a cosmetology or esthetician salon under section 9.3 of the act. Subsection (a) would set forth the conditions that must be met to practice massage therapy within a cosmetology or esthetician salon, as required by section 9.3(a) of the act. Subsection (a)(1) would provide that the massage therapy licensee must be the owner of the salon or employed by the salon and is not an independent contractor as required by section 9.3(a)(1) of the act. Subsection (a)(2) would provide that the massage therapist would be required to practice in accordance with this section, Chapter 20 (relating to State Board of Massage Therapy), the act and the Massage Therapy Law. Subsection (a)(2)(i) provides that the salon owner may only employ a massage therapist who is currently licensed by the State Board of Massage Therapy. The subsection further provides that the salon owner is responsible to ensure each massage therapist employed by the salon complies with this section, Chapter 20, the act and the Massage Therapy Law. Subsection (a)(2)(ii) provides that the message therapist who is the owner of the salon shall comply with regulations applicable to salon owners as set forth in the Board's regulations in §§ 7.50—7.66 (relating to licensure and management of salons).

Subsection (a)(3) requires that a salon owner provide an appropriate level of privacy for clients. Subsection (a)(3)(i)(A) and (B) clarifies that when a massage therapist is practicing in a separate massage therapy room of the salon, or in the areas of the salon used for cosmetology or esthetics, the massage therapist is practicing in the licensed square footage of the salon. Furthermore, subsection (a)(3)(i)(A) and (B) clarifies what services require a separate massage therapy room by specifically listing the massage services that do not require the use of physical barriers. The Board's proposed regulation reflects section 9.3(a)(3)(i) of the act which provides that no physical barriers separating the areas used for massage therapy from the areas used for cosmetology or esthetics,

as defined in section 1 of the act (63 P.S. § 507), shall be required when a massage therapist performs massage services that a cosmetologist or esthetician is authorized to perform. Subsection (a)(3)(ii) clarifies that when a massage therapist is practicing in a separate massage therapy room of the salon, the massage therapist is practicing in the licensed square footage of the salon. Furthermore, subsection (a)(3)(ii) requires that a salon owner provide separate massage therapy rooms with permanent walls and doors to ensure privacy for clients receiving massage services from a massage therapist when the services are beyond the practice of cosmetology or esthetics, as required by section 9.3(a)(3)(i) of the act.

Subsection (a)(3)(ii)(A)—(C) sets forth standards for separate massage therapy rooms. Subsection (a)(3)(ii)(A) requires that massage therapy rooms be a minimum of 120 square feet in size, which is a generally accepted industry standard based on the size of a standard massage table (73 inches × 30 inches) and allows room for a massage therapist to safely maneuver around it (approximately 3 to 4 feet on each side of the table). The Board feels this requirement is necessary because § 7.76(a) (relating to floor space) requires an "additional area of at least 60 square feet. . .for each additional licensee in the salon." Accordingly, it is likely that salon owners unfamiliar with the practice of massage therapy will expect massage therapists to perform massage therapy in rooms designed for the practice of cosmetology or esthetician services (that is, rooms with little more than 60 square feet in size). A 60-square-foot room does not provide a massage therapist sufficient room to safely maneuver around a standard-sized massage table and keep the necessary supplies at hand. Additionally, massage therapy clients are often asked to position their arms at a 90-degree angle to the body, and the massage therapist must safely maneuver around the client's outstretched arms. Moreover, clients are typically expected to use the massage therapy room to disrobe and transition to the massage therapy table. Accordingly, massage therapy rooms frequently include a chair, as well as clothing storage such as clothing hooks or a shelving unit. It would be a safety risk to expect a massage therapist to safely perform massage therapy multiple times a day in any room smaller than 120 square feet. Accordingly, after discussing this issue at public board meetings, and reaching an agreement with the State Board of Massage Therapy, the Board is of the opinion that a minimum room size of 120 square feet is appropriate.

Subsection (a)(3)(ii)(B) discusses the storage of linens or other supplies used by a massage therapist in a salon. Sections 7.71a—7.71c (relating to equipment and supplies for esthetician salon; equipment and supplies for a nail technology salon; and equipment and supplies for a natural hair braiding salon) set minimum standards for equipment and supplies, detailing what must be available to licensees, and where linens must be stored. Being that massage therapists working in salons will be required to adhere to both State Board of Massage Therapy regulations and the Board's regulations, the Board believes that it must clarify where massage therapists may store linens and other supplies. Accordingly, subsection (a)(3)(ii)(B) allows the massage therapist to store linens or other supplies used for massage therapy in the massage therapy room or in the salon in a space designated by the salon owner.

Subsection (a)(3)(ii)(C) states esthetician services may be provided in the massage therapy room, so long as esthetician services were not provided concurrent to the massage therapy services, as required by section 9.3(a)(3)(iii) of the act.

Subsection (b) requires a massage therapist practicing massage therapy within the approved premises of a salon to practice in accordance with the act and correlating regulations, the State Board of Massage Therapy's regulations and the Massage Therapy Law, as required by section 9.3(a)(2) of the act.

Subsection (c) states that a massage therapist practicing in accordance with section 9.3 of the act would be subject to inspection by both the Board and the State Board of Massage Therapy, as required by section 9.3(b) of the act.

Subsection (d) states that a massage therapist practicing in a salon, who violates the act or the Massage Therapy Law, is subject to discipline by the State Board of Massage Therapy, as required by section 9.3(c) of the act.

Fiscal Impact and Paperwork Requirements

There will not be a negative fiscal impact on licensees or the Board. Section 9.3 of the act was added September 24, 2014, and permitted the practice of massage therapy within the licensed square footage of a cosmetology or esthetician salon as of November 24, 2014. The Board does not track how many massage therapists work in salons. However, it is unlikely that any significant number of massage therapists have been practicing in rooms smaller than 120 square feet because the practice of massage therapy in any room smaller than 120 square feet would be difficult and potentially dangerous. However, the small number of massage therapists who may be currently working in rooms smaller than 120 square feet will have to find a way to comply with the proposed regulation. For the reasons explained in this preamble, it is in the public interest to require that massage therapy be performed in a room large enough to accommodate all that is required.

While section 9.3(b) of the act indicates that massage therapists practicing in salons are subject to inspection by the Board and the State Board of Massage Therapy, the Board currently conducts these inspections, while the State Board of Massage Therapy does not. Accordingly, the Board's fees are structured to allow for these inspections.

Sunset Date

The Board continuously monitors the effectiveness of its regulations on a fiscal year and biennial basis. Therefore, no sunset date has been assigned.

Regulatory Review

Under Section 5(a) of the Regulatory Review Act (71 P.S. § 745.5(a)), on December 4, 2023, the Board submitted a copy of this proposed rulemaking and a copy of a regulatory analysis form to the Independent Regulatory Review Commission (IRRC) and to the chairperson of the Consumer Protection and Professional Licensure Committee of the Senate and the chairperson of the Professional Licensure Committee of the House of Representatives. A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, IRRC may convey comments, recommendations or objections to the proposed rulemaking within 30 days of the close of the public comment period. The comments, recommendations or objections shall specify the regulatory review criteria that have not been met. The Regulatory Review

Act specifies detailed procedures for review, prior to final publication of the rulemaking, by the Commissioner, the General Assembly and the Governor.

Public Comment

Interested persons are invited to submit written comments, suggestions or objections regarding this proposed rulemaking to the Regulatory Counsel, Department of State, P.O. Box 69523, Harrisburg, PA 17106-9523 or RA-STRegulatoryCounsel@pa.gov, within 30 days following publication of this proposed rulemaking in the *Pennsylvania Bulletin*. Comments should be identified as pertaining to rulemaking 16A-4518 (massage therapy in cosmetology or esthetician salons).

TAMMY O'NEIL,
Chairperson

Fiscal Note: 16A-4518. No fiscal impact; recommends adoption.

Annex A

TITLE 49. PROFESSIONAL AND VOCATIONAL STANDARDS

PART I. DEPARTMENT OF STATE

Subpart A. PROFESSIONAL AND OCCUPATIONAL AFFAIRS

CHAPTER 7. STATE BOARD OF COSMETOLOGY

PRACTICE OF MASSAGE THERAPY IN COSMETOLOGY OR ESTHETICIAN SALONS

(*Editor's Note*: Section 7.150 is proposed to be added and is printed in regular type to enhance readability.)

§ 7.150. Practice of massage therapy in cosmetology or esthetician salons.

(a) A massage therapist licensed under the act of October 9, 2008 (P.L. 1438, No. 118) (63 P.S. §§ 627.1—627.50), referred to as the Massage Therapy Law, is permitted to practice massage therapy within the approved premises of a licensed cosmetology salon or a licensed esthetician salon if all of the following conditions are met:

(1) The massage therapy licensee is the owner of or employed by the salon and is not an independent contractor.

(2) The massage therapist practices in accordance with this section, Chapter 20 (relating to State Board of Massage Therapy), the act and the Massage Therapy Law. The following apply:

(i) The salon owner may only employ a massage therapist who is currently licensed by the State Board of Massage Therapy. The salon owner is responsible to ensure each massage therapist employed by the salon complies with this section, Chapter 20, the act and the Massage Therapy Law.

(ii) A massage therapist who is the owner of the salon shall comply with all of the regulations applicable to salon owners set forth in §§ 7.50—7.66 (relating to licensure and management of salons).

(3) The salon owner provides an appropriate level of privacy for clients in accordance with all of the following:

(i) *Massage therapy services within the scope of practice of the Cosmetology Law.* When a massage therapist is practicing in a separate massage therapy room of the salon or in the areas of the salon used for cosmetology or esthetics, the massage therapist is practicing in the licensed square footage of the salon. Physical barriers separating the areas used for massage therapy services from the areas used for cosmetology or esthetics are not required when a massage therapist provides massage therapy services that are within the scope of practice of cosmetology as defined in § 7.1 (relating to definitions) as follows:

(A) Massage therapy services of the scalp, face, arms or hands, or the upper part of the body.

(B) Massage therapy services of the feet or the lower legs of an individual up to the individual's knee.

(ii) *Massage therapy services beyond the scope of practice of the Cosmetology Law.* When a massage therapist is practicing in a separate massage therapy room of the salon, the massage therapist is practicing in the licensed square footage of the salon. A salon owner shall provide separate massage therapy rooms with permanent walls and doors to ensure privacy for clients receiving massage therapy services from a massage therapist when the massage therapy services are beyond the scope of practice of cosmetology or esthetics as provided in § 7.1. The following apply:

(A) The size of the separate massage therapy room must be a minimum of 120 square feet.

(B) The massage therapist may store linens or other supplies in the separate room provided or in the salon in a space designated by the salon owner.

(C) Esthetician services may be provided to a client in the same room where the client receives massage therapy, provided these services are not performed concurrently.

(b) A massage therapist providing massage therapy services within the approved premises of a salon shall practice in accordance with the act, this chapter and the Massage Therapy Law.

(c) A massage therapist providing massage therapy services within the approved premises of a salon is subject to inspection by the State Board of Massage Therapy and the board.

(d) A massage therapist providing massage therapy services within the approved premises of a salon who violates this section, the act or the Massage Therapy Law is subject to discipline by the State Board of Massage Therapy.

[Pa.B. Doc. No. 23-1753. Filed for public inspection December 15, 2023, 9:00 a.m.]

STATE BOARD OF MEDICINE

[49 PA. CODE CH. 18]

Physician Assistants

The State Board of Medicine (Board) proposes to amend Chapter 18, Subchapter D (relating to physician assistants) to read as set forth in Annex A. Specifically, the Board proposes amendments to §§ 18.122, 18.141—18.144, 18.151—18.154, 18.156—18.159, 18.161, 18.162, 18.171 and 18.172. The Board also proposes to delete § 18.155 (relating to satellite locations).

Effective Date

This proposed rulemaking will be effective upon publication of the final-form rulemaking in the *Pennsylvania Bulletin*.

Statutory Authority

The primary statutory authority for this proposed rulemaking is the act of October 7, 2021 (P.L. 418, No. 79) (Act 79), which amended section 13 of the Medical Practice Act of 1985 (act) (63 P.S. § 422.13) by removing certain restrictions on physician assistant practice to provide greater autonomy in the practice of the profession. Under section 4 of Act 79, the Board is authorized to promulgate regulations necessary to carry out the act.

Section 13(c) of the act authorizes the Board to promulgate regulations which define the services and circumstances under which a physician assistant may perform a medical service.

Section 8 of the act (63 P.S. § 422.8) authorizes the Board to adopt these regulations as are reasonably necessary to carry out the purposes of the act, including the licensure of physician assistants.

Background and Need for Amendments

This proposed rulemaking is needed to effectuate Act 79 which is meant to help physician assistants work and practice with increased efficiency in this Commonwealth, which is one of the premier states for physician assistant education with more than 20 physician assistant programs offered in this Commonwealth. While many physician assistants receive their education in this Commonwealth, prior legislation made it less appealing for physician assistants to stay and practice in this Commonwealth. Act 79 modernizes physician assistant practice in this Commonwealth by (1) placing a physician assistant on the Board with a permanent seat, (2) removing the requirement that a supervising physician countersign 100% of the patient files, (3) allowing all written agreements between physicians and physician assistants to be "filed" with the Board instead of "approved" by the Board, (4) outlining appropriate supervision requirements based on the needs of the physicians, physician assistants and overall health care system and (5) increasing the number of physician assistants a supervising physician may have primary responsibility over from four to six physician assistants.

Description of Proposed Amendments

The Board proposes comprehensive amendments to Chapter 18, Subchapter D to update the regulations to reflect current practices and to incorporate the changes made to the act by Act 79.

In § 18.122 (relating to definitions), the Board proposes to amend several definitions as follows:

The definition of "ARC-PA" is proposed to be amended to include the complete formal name of the Accreditation Review Commission on Education for Physician Assistants.

This proposed regulation creates a definition for "health care facility" to mirror the definition of "health care facility" as defined in section 103 of the Health Care Facilities Act (35 P.S. § 448.103). The act references both health care facilities and the Health Care Facilities Act (35 P.S. §§ 448.101—448.904b) but this term is not defined in the Board's regulations. The existing regulations refer only to hospital and medical facility which is not inclusive of all licensed facilities under the Health Care Facilities Act in which a physician assistant may work.

The definition of "medical care facility" is proposed to be deleted in its entirety. The act does not define or even refer to a medical care facility. The act refers only to a health care facility as defined by the Health Care Facilities Act. To make the regulations consistent with the act, the term "medical care facility" will be replaced throughout the regulations with the term "health care facility."

The definition of "order" is proposed to be amended to delete the requirement that onsite administration of a drug be limited to a hospital, medical care facility or office setting. The existing language is meant to encompass all practice locations in which a physician assistant might administer a drug; however, this language is outdated. Currently, physician assistants practice in, and administer drugs onsite in, more locations than hospitals, medical care facilities or office settings. There may be scenarios where a physician assistant administers a drug at a sporting event, a pop-up clinic or in a pharmacy. The deletion of the reference to a hospital, medical care facility and office setting will allow the definition to apply in all onsite settings in which a drug may be administered onsite by a physician assistant.

The definition of "physician assistant program" proposes to be amended to remove the requirement that the training and education program for physician assistants be recognized by the Board "and" accredited by the CAHEA, the CAAHEP, ARC-PA or a successor agency. The Board has already approved training and education programs accredited by CAHEA, the CAAHEP or ARC-PA so the requirement for Board recognition is redundant. Instead, the proposed language changes "and" to "or" so that the Board will have the authority to approve new accrediting organizations that are not successor organizations of CAHEA, the CAAHEP or ARC-PA.

The definition of "prescription" is proposed to be updated to current practice by allowing the prescribing to be done electronically since that is how most prescribing presently occurs. Without this amendment, electronic orders for a drug or device would not fall into the definition of "prescription" which could result in the argument being made that the prescribing regulations in §§ 18.151 and 18.158 (relating to role of physician assistant; and prescribing and dispensing drugs, pharmaceutical aids and devices) do not apply. To prevent this, the word "electronic" is proposed to be included in the regulations so that all forms of prescribing are included.

The definition of "primary supervising physician" is proposed to be amended to delete the reference to "directing and personally" supervising consistent with Act 79.

This proposed rulemaking deletes the definition of "satellite location" because it is no longer relevant to the Board's regulations with the enactment of Act 79. The proposed deletion of the term "directing and personally supervising" from the definition of "primary supervising physician" eliminates the basis on which satellite office approval is required. The need for onsite presence on a fixed schedule was the only distinction between a satellite location and a primary practice location.

This proposed rulemaking defines "scope of practice" because Act 79 refers to the term "scope of practice" but does not define its meaning. The proposed definition reflects the role of the physician assistant as set forth in § 18.151(b) and limits the scope of practice of the physician assistant to medical services as set forth in the written agreement. The terms "medical services" and "skills, training and experience" are used in the definition of "scope of practice" because they are consistent with the existing language in § 18.151(b).

The definition of "substitute supervising physician" is proposed to be amended to clarify that the substitute

supervising physician is either designated in a written agreement on file with the Board or kept on file at the practice location where the physician assistant is rendering services. The Board does not think it is necessary to designate all substitute physicians in the written agreement. It is a cumbersome and overly burdensome requirement, and the Board proposes to simplify this reporting requirement.

The definition of "supervising physician" is proposed to be amended to clarify that the physician assistant may serve a primary supervising physician and one or more substitute supervising physicians as long as at least one substitute supervising physician is named in the written agreement on file with the Board. A substitute supervising physician must either be named in the written agreement on file with the Board or the relationship as a substitute supervising physician must be maintained at the practice location where the physician assistant practices. The term supervising physician refers to both the primary supervising physician and any of the substitute supervising physicians.

The definition of "supervision" is proposed to be amended to delete the requirement that the supervising physician has "personal direction" over the physician assistant. This proposed amendment reflects the language of Act 79 which deletes the requirement that the supervising physician "directly and personally" supervise a physician assistant. Subsection (i) is proposed to be further amended to delete the phrase "by radio, telephone or other telecommunications device" when referring to how a supervising physician and physician assistant may be in contact with each other. The terms that are proposed to be deleted are outdated and do not cover all the ways in which a physician assistant and supervising physician may contact each other. Furthermore, it is not necessary to list all means of communication in the regulation. In subsection (ii)(A), the term "active and continuing" is proposed to be deleted since the written agreement will outline the degree of oversight the supervising physician will have over the physician assistant. Phrases related to "personal" review are deleted in subsection (ii)(C) consistent with Act 79. Finally, this proposed rulemaking deletes reference to the review of patient records being done within 10 days and instead requires the supervising physician to review patient records in accordance with § 18.142(2) (relating to written agreements). Section 18.142(2) requires the primary or substitute supervising physician to countersign the patient record as required by Act 79. The relevant language of Act 79 allows the supervising physician to determine countersignature requirements except for when the physician assistant is practicing in the first 12 months post-graduation or the first 12 months practicing in a new specialty. In those two scenarios, the supervising physician must countersign 100% of the patient records.

This proposed rulemaking defines the term "unable to supervise" to designate when the physician assistant may provide services to a substitute supervising physician. It is important to note that the primary supervising physician does not have to be physically unable to supervise for the physician assistant to serve a substitute which was not clear in the current language of the regulations.

The definition of "written agreement" is proposed to be amended to clarify that it is an agreement between the physician assistant and the primary supervising physician. While substitute supervising physicians may be named in the written agreement, the agreement is only signed by the primary supervising physician and the physician assistant.

Section 18.141(2) (relating to criteria for licensure as a physician assistant) is proposed to be amended to require that approved physician assistant programs be accredited as provided for in § 18.131 (relating to recognized educational programs/standards). This proposed rulemaking deletes the requirement that the physician assistant program be "recognized by the Board." This additional language is not necessary because the Board has already approved the accredited programs referenced in § 18.131(a) and allows the Board to recognize additional programs in § 18.131(b).

Section 18.142(a)(1) is proposed to be amended to reflect that the written agreement must identify and be signed by the physician assistant and the primary supervising physician. Subsection (a)(1) further provides that the primary supervising physician must be a medical doctor. In smaller office practice settings, the physician assistant may only serve the primary supervising physician named in the written agreement on file with the Board or the substitute supervising physician if one is named in the written agreement on file with the Board. However, in a larger practice setting, such as an orthopedic institute, the physician assistant might serve several substitute supervising physicians in addition to their primary supervising physician. In this scenario, the physician assistant's written agreement would name the primary supervising physician and at least one substitute supervising physician. A list of all other substitute supervising physicians that the physician assistant serves would be maintained at that practice location where the physician assistant practices. If the physician assistant is providing services in a health care facility as defined by the Health Care Facilities Act, the physician assistant would file a written agreement with the Board which names a primary supervising physician and at least one substitute, but again, the physician assistant may serve numerous substitute physicians in that facility. In accordance with section 13(g) of the act, the attending physician for the patient that the physician assistant is seeing would become the primary supervising physician for that patient and take on responsibility for the medical services rendered by the physician assistant in the care of that patient. Also, the facility will maintain a list of all the supervising physicians that the physician assistant serves at that practice location.

The current regulations in subsection (a)(1) require the written agreement to include every physician that the physician assistant would be serving, including the primary supervising physician and all substitute supervising physicians. However, this requirement resulted in the Board becoming overburdened with written agreement change forms every time the physician assistant served a new substitute supervising physician. The Board does not think it is necessary to designate all substitute physicians in the written agreement. It is a cumbersome and overly burdensome requirement, and the Board proposes to simplify this reporting requirement.

The proposed language in subsection (a)(2) deletes the requirement that the written agreement specify the "manner in which the physician assistant will be assisting each named physician" and "the functions to be delegated to the physician assistant." The outdated language is proposed to be replaced with the requirement that the written agreement specify the physician assistant's scope of practice, consistent with section 13(e)(2) of the act. Subsection (a)(3) proposes to delete the requirement that the written agreement specify the "manner in which the physician assistant will be assisting each named physician, including the frequency of personal contact with the physician assistant" and replace that language with "the

nature and degree of supervision the primary supervising physician will provide the physician assistant." This proposed amendment reflects the intention of section 13(e)(3) of the act to allow the supervising physician to determine the appropriate supervision necessary. The proposed language in subsection (a)(4) deletes the existing regulatory language and replaces it with the requirement that the written agreement "be prepared and submitted by the primary supervising physician, the physician assistant or a delegate of the primary supervising physician and the physician assistant." The Board proposes to add, "[i]t shall not be a defense in any administrative or civil action that the physician assistant acted outside the scope of the Board-filed description or that the supervising physician utilized the physician assistant outside the scope of the Board-filed description because the supervising physician or physician assistant permitted another person to represent to the Board that the description had been approved by the supervising physician or physician assistant." This provision is consistent with the language of section 13(e)(4) of the act. The outdated language in subsection (a)(5) relating to the timing of when the countersignature must occur—within 10 days—is proposed to be deleted and replaced by a reference to the written agreement because section 13(d.1)(3) of the act directs the primary supervising physician to determine the countersignature requirements of patient records. Proposed subsection (a)(5)(ii)(A) and (B) includes the two exceptions to when the supervising physician may determine the countersignature requirement. Subsection (a)(5)(ii)(A) requires that the primary supervising physician countersign 100% of patient records within a reasonable time, not to exceed 10 days, for the first 12 months of the physician assistant's practice post-graduation. Subsection (a)(5)(ii)(B) requires that the primary supervising physician countersign 100% of patient records within a reasonable time, not to exceed 10 days, for the first 12 months of the physician assistant's practice in a new specialty. Subsection (a)(6) is proposed to be amended to require that the written agreement identify the primary practice setting that the physician assistant will serve. This proposed rulemaking adds subsection (a)(7) to require the physician assistant to name at least one substitute supervising physician in the written agreement if the physician assistant intends to practice if the primary supervising physician becomes permanently unable to supervise. The proposed amendment to § 18.143(a)(3) (relating to criteria for registration as a supervising physician) prohibits a physician assistant from practicing when the primary supervising physician is permanently unable to supervise.

Section 18.142(b) proposes to delete the requirement that written agreements be approved by the Board. Instead, this section is proposed to specify that the written agreement must be "filed with" the Board to mirror the language of section 13(e)(6) of the act. The remainder of the existing language is proposed to be deleted because the Board will not verify compliance of the written agreements with the act or regulations, except for audited written agreement applications. Additional language is proposed to be added to clarify that the written agreements become effective upon submission to the Board since the Board is no longer required to review and approve written agreements prior to approval.

Section 18.142(c) proposes to delete the word "immediate" and instead proposes to use the term "upon request" when referring to the physician assistant and the primary supervising physician's duty to provide access to written agreements. Currently there is not, and never has been, a statutory requirement that written agreements be provided immediately. The Board is concerned that the existing language may cause the physician assistant or the primary supervising physician to compromise patient care if they are required to stop and immediately produce the written agreement within that moment.

Section 18.143(a) proposes amendments to clarify that the Board registers the primary supervising physician as opposed to all substitute supervising physicians that the physician assistant may serve. Subsection (a)(3) is proposed to be amended to delete the requirement that the physician assistant provide a list of the other physicians who are serving as supervising physicians. The proposed amendment requires instead that the physician assistant provide the name and license number of "at least one" primary supervising physician and "a substitute." The Board believes that the current regulatory requirement is unnecessary and is overly burdensome. This proposed rulemaking clarifies that the physician assistant will refrain from practicing unless at least one substitute supervising physician is named in the written agreement on file with the Board.

Subsection (b) is proposed to be deleted in its entirety because satellite locations no longer need to be treated differently from primary practice locations. The act deleted the phrase "directly and personally" supervise from the definition of "primary supervising physician." Since onsite supervision was the only distinction between satellite offices and primary practice locations, the elimination of "personal" supervision has eliminated the necessity of distinguishing satellite offices. Subsection (c) proposes to clarify that the Board will maintain a list of registered primary supervising physicians since substitute supervising physicians are not registered with the Board. This list would include the primary supervising physician's name and address on file with the Board, along with the date of the filing of the written agreement, since that would be the written agreement effective date, and the names of all physician assistants under the primary supervising physician's supervision. This subsection proposes to require only one substitute supervising physician to be named in the written agreement. This proposed rulemaking requires the Board to maintain on file the date that the written agreement was filed with the Board because that is the date that the written agreement became effective. The reference to satellite locations is deleted consistent with Act 79.

Section 18.144(4) (relating to responsibility of primary supervising physician) is proposed to be deleted in its entirety because it is not consistent with the language in Act 79. The degree of supervision is already encompassed in the regulations regarding written agreements. Paragraph (5), which requires that the physician assistant see each hospitalized patient at least once, is also proposed to be deleted because it is not consistent with current practice. The frequency of how often a hospitalized patient should be seen is determined by the medical care or health care facility, through its bylaws, or by the supervising physician. Paragraph (6) proposes to delete the phrase "by the physician assistant relayed to other health care practitioners" to make this subsection more general and encompassing regarding the supervising physician's duty to provide access to written agreements and clarification of orders and prescriptions. Paragraph (7) proposes to clarify that the primary supervising physician must maintain oversight and responsibility for the medical services provided by the physician assistant consistent with Act 79. Paragraph (8) proposes to require the practice or facility to maintain a current list of all

substitute supervising physicians with which a physician assistant will work. This may include additional substitute supervising physicians who will assume responsibility of the physician assistant in the primary supervising physician's absence. The Board proposes to add paragraph (9) which requires that the Board be notified of any change in the primary practice address using a written agreement change form within 15 days. This will ensure the Board is aware of where the physician assistant is working.

Section 18.151(a) is proposed to be amended to reflect that the physician assistant practices medicine as provided for in the written agreement. A written agreement not only includes information such as name, address and license number of the primary supervising physician and physician assistant, but it would also outline information such as specialty of the primary supervising physician, whether or not the physician assistant will be working in a health care facility, whether the physician assistant will prescribe or dispense drugs, and if so, what schedule categories, the physician assistant's scope of practice, and the nature and degree of supervising the primary supervising physician will provide. This proposed language reflects that the supervising physician no longer "directly and personally" supervises the physician assistant. The proposed amendment to this subsection also reflects the requirement of Act 79 that the services provided by the physician assistant must be provided for in the written agreement. Subsection (b) proposes to delete the reference to the supervising physician directing the physician assistant since the supervising physician no longer "directly and personally" supervises the physician assistant. This subsection is proposed to be further amended to require the physician assistant to provide medical services that are within the physician assistant's scope of practice, consistent with the language section 13(e)(2) of the act. Subsection (c) proposes to delete the prohibition that a physician assistant may not determine the cause of death. This proposed amendment updates the language to comply with current law, a legislative change enacted by the act of July 7, 2017 (P.L. 296, No. 17).

Section 18.152(a)(2) (relating to prohibitions) is proposed to be deleted in its entirety because it is redundant to the information in subsection (a)(1). The written agreement determines whether a physician assistant may prescribe or dispense drugs. Subsection (a)(3) is also proposed to be deleted in its entirety. The fact that a primary supervising physician no longer "directly and personally" supervises physician assistants has eliminated the distinction that previously existed between a satellite office and a primary practice setting. There is no longer a need for the registration of satellite offices with the Board. Subsection (a)(4) proposes to delete the prohibition of billing patients for services provided. This amendment reflects current practice since Medicare allows for independent billing by physician assistants under the Physician Assistant Medicare Payment Rules of 2022, which became effective on January 1, 2022. Subsection (a)(5) proposes to use the gender-neutral term "the physician assistant." The existing language in subsection (a)(6) is proposed to be deleted and the terminology would be amended to delete outdated advertising methods. The amended language prohibits a physician assistant from intentionally advertising as an independent practitioner or holding themselves out as an independent practitioner. This proposed amendment maintains the prohibition against independent practice while recognizing that physician assistants may be listed on panels or under a medical provider in many settings. Subsection (a)(8) is proposed to be deleted in its entirety as the language is redundant. This prohibition is covered in other sections of 13(e) of the act, which prohibits a physician assistant from assisting a physician in a manner not described in the agreement or without the nature and degree of supervision described in the agreement. Subsection (b)(2) is proposed to be amended to increase the ratio of how many physician assistants a primary supervising physician may have primary responsibility of from two to six. This amendment includes additional language that the Board may approve the supervision of additional physician assistants. These amendments are consistent with Act 79.

Section 18.153(b) (relating to executing and relaying medical regimens) is proposed to be deleted in its entirety. Subsection (b) no longer applies because the supervising physician is no longer required to be on site under section 13(d) of the act. Additionally, this language is not required by Act 79. Subsection (c) proposes to delete the now outdated language which requires the countersignature of patient records by the supervising physician within 10 days. Instead, the proposed language of this section reflects that the countersignature requirements will be specified in the written agreement as required by Act 79 in section 13(d.1)(3) of the act. Subsection (d) proposes to delete the requirement that the physician assistant and the primary supervising physician provide "immediate" access to the written agreement. There is not currently, and never has been, a statutory requirement that written agreements be provided immediately. There was concern that existing language may cause the physician assistant or the primary supervising physician to compromise patient care if they are required to stop and immediately produce the written agreement within that moment. Additionally, all references to "medical care facility" is replaced with "health care facility."

Section 18.154(a) (relating to substitute supervising physician) proposes to delete the language indicating that all substitute supervising physicians must be registered with the Board. This proposed amendment requires the written agreement to name at least one substitute supervising physician that the physician assistant may serve. A list of all other substitute supervising must be maintained at the practice or facility, as required under § 18.144(8). Section 18.154(c) proposes to require that the substitute supervising physician retain responsibility for the medical services that the physician assistant renders. This proposed rulemaking adds subsection (e) to require that in the event of the primary supervising physician becoming permanently unable to supervise, the substitute supervising physician will assume primary responsibility for the physician assistant until a new written agreement can be filed. However, this arrangement cannot exceed 30 days. This proposed amendment is necessary because a temporary transition period is needed if the supervising physician dies or leaves their employment, and this language will allow the physician assistant to keep practicing if it takes some time to have a new written agreement filed with the Board. The Board does not currently have regulations that address the death or other sudden and unexpected departure of a primary supervising physician. Currently, the death or departure of a primary supervising physician negates the written agreement and prohibits the physician assistant from practicing which, in turn, causes a gap in patient care. This proposed amendment will cure that problem.

Section 18.155 (relating to satellite locations) is proposed to be deleted in its entirety because this section is no longer relevant. Act 79 removes the requirement that

the supervising physician be onsite. Additionally, since the supervising physician no longer "directly and personally" supervises the physician assistant, there is no longer a distinction between satellite offices and primary practice locations. Therefore, there is no longer a need to regulate satellite offices.

Section 18.156(b) (relating monitoring and review of physician assistant utilization) is proposed to be amended with the Board addition of the term "inspection" to clarify the type of reports to be submitted to the Board. Additionally, the Board proposes to delete the reference to satellite locations because it is no longer relevant to the Board's regulations with the enactment of Act 79.

Section 18.157(a) (relating to administration of controlled substances and whole blood and blood components) is proposed to be amended to replace the term "hospital" with "health care facility" so that this section would apply to the administration of controlled substances in all licensed facilities and not just hospitals, medical care facilities and office settings.

Section 18.158(a)(4) (relating prescribing and dispensing drugs, pharmaceutical aids and devices) is proposed to be amended to reflect that a physician assistant must prescribe or dispense a drug for a patient in accordance with the written agreement and not per the supervising physician's instructions. This language is consistent with the rest of the Board's regulations which refer to the written agreement only and not the supervising physician's instructions. Subsection (b) is proposed to be amended to no longer refer to this section as "prescription blanks" since that is an outdated term. Instead, the section is proposed to be entitled "prescriptions" and would include prescription blanks and electronic prescriptions. The purpose of this proposed amendment is to expand the existing language to include electronic prescriptions, recognizing that most medical practices utilize electronic prescriptions. The term hospital is replaced with "health care facility." Currently, in inappropriate prescribing scenarios, the pharmacist would contact the physician assistant as the prescriber, who would then address it with the supervising physician and the patient. Subsection (d)(3) is proposed to be deleted in its entirety because there is no longer an onsite presence requirement. Additionally, the primary supervising physician no longer "directly and personally" supervises the physician assistant. The requirement that the physician assistant report a drug prescribed in the supervising physician's absence would be outlined in the written agreement. Subsection (d)(4) is proposed to be amended to require that countersignatures must occur as outlined in the written agreement, consistent with section 13(d.1)(3) of the act as amended by Act 79, and as required in § 18.142(a)(5)(ii). Subsection (d)(5) proposes to delete the requirement that the physician assistant and primary supervising physician provide immediate access to the written agreement since immediate access may not always be possible. Currently there is not, and never has been, a statutory requirement that written agreements be provided immediately. There was concern that existing language may cause the physician assistant or the primary supervising physician to compromise patient care if they are required to stop and immediately produce the written agreement within that moment.

Section 18.159 (relating to medical records) proposes to delete the requirement that the supervising physician review medical records prepared by the physician assistant within 10 days. The proposed amendment requires the supervising physician to review the medical records in a timely manner as described in the written agreement and as required in § 18.142(a)(5)(ii). This way, the supervising physician can determine how often they will review the physician assistant's medical records, if at all, so long as it is still a timely review.

Section 18.161 (relating to physician assistant employed by medical care facilities) proposes to delete the term "medical care facility" and replace it with the term "health care facility" to cover all practice settings in which a physician assistant may work and to maintain consistency between the regulation and the act. Subsection (b), which limits a physician assistant from being responsible to more than three supervising physicians in a medical care facility, is proposed to be deleted in its entirety. This limitation is not imposed by Act 79, or the act and it is not practical for physician assistants who cover multiple services within a facility. This proposed rulemaking deletes the first portion of subsection (c), which states that a medical care facility is not required to hire or employ physician assistants because it is redundant with subsection (a) which states that physician assistants "may" be employed by a medical care facility. The Board proposes to delete the term "hospitalized" from subsection (c) since not all facility patients are hospitalized. Finally, the Board proposes to add subsection (e) which addresses attending physicians in a health care facility licensed under the Health Care Facilities Act. This section states that the attending physician of record for a particular patient shall act as the primary supervising physician for the physician assistant while that patient is under the care of the attending physician. This proposed language is consistent with section 13(g) of the act.

Section 18.162(a) (relating to emergency medical services) proposes to delete the requirement that the physician assistant only provide medical services in an emergency medical care setting if they are under the supervision of the supervising physician. The remaining language requires that the physician assistant have training in emergency medicine and is provided for in the written agreement.

Section 18.171(a)(2) (relating to physician assistant identification) proposes to be deleted in its entirety because the medical services that a physician assistant may perform and the way they shall be performed is determined by the written agreement not by regulatory language. Subsection (c) proposes to delete the reference to satellite locations as they are no longer relevant to this regulation.

Section 18.172 (relating to notification of changes in employment) proposes to update the language to current practice by deleting references to required notification being in writing from the primary supervising physician. This language is outdated because notification forms are now only available online.

Fiscal Impact and Paperwork Requirements

This proposed rulemaking will not have any fiscal impact on licensees, the Board or the Commonwealth, nor is any additional paperwork anticipated.

Sunset Date

The Board continuously monitors its regulations; therefore, no sunset date has been assigned.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P.S. § 745.5(a)), on November 27, 2023, the Board submitted a copy of this proposed rulemaking and a copy of a Regulatory Analysis Form to the Independent Regu-

latory Review Commission (IRRC) and to the chairperson of the Consumer Protection and Professional Licensure Committee of the Senate (SCP/PLC) and the chairperson of the Professional Licensure Committee of the House of Representatives (HPLC). A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, IRRC may convey comments, recommendations or objections to the proposed rulemaking within 30 days of the close of the public comment period. The comments, recommendations or objections must specify the regulatory review criteria in section 5.2 of the Regulatory Review Act (71 P.S. § 745.5b) which have not been met. The Regulatory Review Act specifies detailed procedures for review prior to final publication of the rulemaking by the Board, the General Assembly and the Governor.

Public Comment

Interested persons are invited to submit written comments, recommendations or objections regarding this proposed rulemaking to the Board Counsel, State Board of Medicine, P.O. Box 69523, Harrisburg, PA 17106-5923, RA-STRegulatoryCounsel@pa.gov within 30 days following publication of this proposed rulemaking in the *Pennsylvania Bulletin*. Reference 16A-4955 (Physician Assistants) when submitting comments.

MARK B. WOODLAND, MS, MD,
Chairperson

Fiscal Note: 16A-4955. No fiscal impact; recommends adoption.

Annex A

TITLE 49. PROFESSIONAL AND VOCATIONAL STANDARDS

PART I. DEPARTMENT OF STATE

Subpart A. PROFESSIONAL AND OCCUPATIONAL AFFAIRS

CHAPTER 18. STATE BOARD OF MEDICINE—PRACTITIONERS OTHER THAN MEDICAL DOCTORS

Subchapter D. PHYSICIAN ASSISTANTS

GENERAL PROVISIONS

§ 18.122. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

ARC-PA—The Accreditation Review Commission **on Education for Physician Assistants**.

Administration—The direct application of a drug, whole blood, blood components, diagnostic procedure or device, whether by injection, inhalation, ingestion, skin application or other means, into the body of a patient.

* * * * *

Emergency medical care setting—

(i) A health care setting which is established to provide emergency medical care as its primary purpose.

(ii) The term does not include a setting which provides general or specialized medical services that are not routinely emergency in nature even though that setting provides emergency medical care from time to time.

***Health care facility*—As defined in section 103 of the Health Care Facilities Act (35 P.S. § 448.103).**

[*Medical care facility*—An entity licensed or approved to render health care services.]

Medical regimen—A therapeutic, corrective or diagnostic measure performed or ordered by a physician, or performed or ordered by a physician assistant acting within the physician assistant's scope of practice, and in accordance with the written agreement between the supervising physician and the physician assistant.

Medical service—An activity which lies within the scope of the practice of medicine and surgery.

NCCPA—The National Commission on Certification of Physician Assistants, the organization recognized by the Board to certify and recertify physician assistants by requiring continuing education and examination.

Order—An oral or written directive for a therapeutic, corrective or diagnostic measure, including a drug to be dispensed for onsite administration **[in a hospital, medical care facility or office setting]**.

Physician—A medical doctor or doctor of osteopathic medicine.

* * * * *

Physician assistant program—A program for the training and education of physician assistants which is recognized by the Board **[and]** **or** accredited by the CAHEA, the CAAHEP, ARC-PA or a successor agency.

Prescription—

(i) A written**, electronic** or oral order for a drug or device to be dispensed to or for an ultimate user.

(ii) The term does not include an order for a drug which is dispensed for immediate administration to the ultimate user; for example, an order to dispense a drug to a patient for immediate administration in an office or hospital is not a prescription.

Primary supervising physician—A medical doctor who is registered with the Board and designated in the written agreement as having primary responsibility for **[directing and personally]** supervising the physician assistant.

[*Satellite location*—A location, other than the primary place at which the supervising physician provides medical services to patients, where a physician assistant provides medical services.]

***Scope of practice*—The medical services within a physician assistant's skills, training and experience that a physician assistant may perform as set forth in the written agreement.**

Substitute supervising physician—A **[supervising physician]** **medical doctor** who is **[registered with the Board and]** designated in the written agreement **on file with the Board, or maintained at the practice location,** as assuming primary responsibility for a physician assistant when the primary supervising physician is **[unavailable]** **unable to supervise**.

Supervising physician—**[Each physician who is identified in a written agreement as a physician who supervises a physician assistant]** **The primary supervising physician and each substitute supervising physician who supervises a physician assistant, who is either identified in a written agreement on file with the Board or maintained at the practice location where the physician assistant practices**.

Supervision—

(i) Oversight **[and personal direction of,]** and responsibility for, the medical services rendered by a physician assistant. The constant physical presence of the supervising physician is not required so long as the supervising physician and the physician assistant are, or can be, easily in contact with each other **[by radio, telephone or other telecommunications device]**.

(ii) An appropriate degree of supervision includes:

(A) **[Active and continuing overview]** **Overview** of the physician assistant's activities **[to determine that the physician's directions are being implemented]** **as provided for in the written agreement**.

(B) Immediate availability of the supervising physician to the physician assistant for necessary consultations.

(C) **[Personal and regular review within 10 days]** **Review** by the supervising physician of the patient records upon which entries are made by the physician assistant **in accordance with § 18.142(5) (relating to written agreements)**.

***Unable to supervise*—When the primary supervising physician cannot supervise the physician assistant due to temporary absence, the primary supervising physician is working at another location or the physician assistant is providing services for a substitute supervising physician who is either named in the written agreement on file with the Board or maintained at the practice location.**

Written agreement—The agreement between the physician assistant and **primary** supervising physician, which satisfies the requirements of § 18.142 **[(relating to written agreements)]**.

LICENSURE OF PHYSICIAN ASSISTANTS AND REGISTRATION OF SUPERVISING PHYSICIANS

§ 18.141. Criteria for licensure as a physician assistant.

The Board will approve for licensure as a physician assistant an applicant who **meets all of the following requirements**:

(1) Satisfies the licensure requirements in § 16.12 (relating to general qualifications for licenses and certificates) including the completion of at least 3 hours of approved training in child abuse recognition and reporting in accordance with § 16.108(a) (relating to child abuse recognition and reporting—mandatory training requirement).

(2) Has graduated from **[a]** **an accredited** physician assistant program **[recognized by the Board]** **as provided for under § 18.131 (relating to recognized educational programs/standards)**.

(3) Has submitted a completed application together with the required fee, under § 16.13 (relating to licensure, certification, examination and registration fees).

(4) Has passed the physician assistant examination.

§ 18.142. Written agreements.

(a) The written agreement required by section 13(e) of the act (63 P.S. § 422.13(e)) satisfies the following requirements. The agreement must:

(1) Identify and be signed by the physician assistant and **[each physician the physician assistant will be assisting who will be acting as a]** **the primary** supervising physician. **[At least one]** **The primary supervising** physician shall be a medical doctor.

(2) Describe the **[manner in which the physician assistant will be assisting each named physician. The description must list functions to be delegated to the physician assistant]** **physician assistant's scope of practice**.

(3) Describe the **[time, place and manner of supervision and direction each named]** **nature and degree of supervision the supervising** physician will provide the physician assistant **[, including the frequency of personal contact with the physician assistant]**.

(4) **[Designate one of the named physicians who shall be a medical doctor as the primary supervising physician]** **Be prepared and submitted by the primary supervising physician, the physician assistant or a delegate of the primary supervising physician and the physician assistant. It shall not be a defense in any administrative or civil action that the physician assistant acted outside of the scope of the Board-filed description or that the supervising physician utilized the physician assistant outside of the scope of the Board-filed description because the supervising physician or physician assistant permitted another person to represent to the Board that the description had been approved by the supervising physician or physician assistant**.

(5) Require that the supervising physician shall countersign the patient record **[completed by the physician assistant within a reasonable amount of time. This time period may not exceed 10 days]** **as outlined in the written agreement and as provided for as follows:**

(i) The primary supervising physician shall determine countersignature requirements of patient records completed by the physician assistant in a written agreement, except as provided under subparagraph (ii).

(ii) The primary supervising physician shall countersign 100% of patient records completed by the physician assistant within a reasonable time, which may not exceed 10 days, during the following periods:

(A) The first 12 months of the physician assistant's practice post-graduation and after the physician assistant has fulfilled the criteria for licensure set forth in section 36(c) of the act (63 P.S. § 422.36(c)).

(B) The first 12 months of the physician assistant's practice in a new specialty in which the physician assistant is practicing.

(6) Identify the **[locations and practice settings]** **primary practice setting** where the physician assistant will serve.

(7) Name at least one substitute supervising physician if the physician assistant intends to practice if the primary supervising physician is permanently unable to supervise.

(b) The written agreement shall be **[approved by]** **filed with** the Board **[as satisfying the requirements in subsection (a) and as being consistent with relevant provisions of the act and regulations contained in this subchapter]** **and shall be effective upon submission to the Board by the primary supervising physician, physician assistant or a delegate of the primary supervising physician and physician assistant**.

(c) **[A]** **Upon request, a** physician assistant or supervising physician shall provide **[immediate]** access to the written agreement to **[anyone seeking to]** confirm the scope of the physician assistant's authority.

§ 18.143. Criteria for registration as a supervising physician.

(a) The Board will register a **primary** supervising physician applicant who:

(1) Possesses a current license without restriction to practice medicine and surgery in this Commonwealth.

(2) Has filed a completed registration form accompanied by the written agreement (see § 18.142 (relating to written agreements)) and the required fee under § 16.13 (relating to licensure, certification, examination and registration fees). The registration requires detailed information regarding the physician's professional background and specialties, medical education, internship, residency, continuing education, membership in American Boards of medical specialty, hospital or staff privileges and other information the Board may require.

(3) Includes with the registration, **[a list, identifying by name and license number, the other physicians who are serving as supervising physicians]** **the name and license number of at least one other physician who is serving as a substitute supervising physician** of the designated physician assistant **[under other written agreements]**. **The physician assistant shall refrain from practicing when the primary supervising physician is permanently unable to supervise unless at least one substitute supervising physician is named in the written agreement on file with the Board.**

(b) **[If the supervising physician plans to utilize physician assistants in satellite locations, the supervising physician shall provide the Board with supplemental information as set forth in § 18.155 (relating to satellite locations) and additional information requested by the Board directly relating to the satellite location]** **[Reserved]**.

(c) The Board will keep a current list of registered **primary** supervising physicians. The list will include the **primary supervising** physician's name, the address **[of residence, current business address]** **on file with the Board**, the date **[of filing]** **the written agreement was filed with the Board**, **[satellite locations if applicable,]** the names of current physician assistants under the **primary supervising** physician's supervision and **[the physicians]** **at least one physician** willing to provide substitute supervision **in accordance with § 18.154 (relating to substitute supervising physician)**.

§ 18.144. Responsibility of primary supervising physician.

A primary supervising physician shall assume the following responsibilities. The supervisor shall:

(1) Monitor the compliance of all parties to the written agreement with the standards contained in the written agreement, the act and this subchapter.

(2) Advise any party to the written agreement of the failure to conform with the standards contained in the written agreement, the act and this subchapter.

(3) Arrange for a substitute supervising physician. **[( ]**See § 18.154 (relating to substitute supervising physician).**[ )]**

(4) **[Review directly with the patient the progress of the patient's care as needed based upon the patient's medical condition and prognosis or as requested by the patient]** **[Reserved]**.

(5) **[See each patient while hospitalized at least once]** **[Reserved]**.

(6) Provide access to the written agreement upon request and provide clarification of orders and prescriptions **[by the physician assistant relayed to other health care practitioners]**.

(7) **[Accept full professional and legal responsibility for the performance of the physician assistant and the care and treatment of the patients]** **Maintain oversight and responsibility for the medical services rendered by physician assistant**.

(8) Maintain at the practice or facility a current list of all substitute supervising physicians with which a physician assistant will work.

(9) Notify the Board of any change in the primary practice address using a written agreement change form within 15 days.

PHYSICIAN ASSISTANT UTILIZATION

§ 18.151. Role of physician assistant.

(a) The physician assistant practices medicine with physician supervision. A physician assistant may perform those duties and responsibilities, including the ordering, prescribing, dispensing, and administration of drugs and medical devices, as well as the ordering, prescribing, and executing of diagnostic and therapeutic medical regimens, as **[directed by the supervising physician]** **provided in the written agreement**.

(b) The physician assistant may provide any medical service **[as directed by the supervising physician]** when the service is within the physician assistant's **[skills, training and experience, forms a component of the physician's]** scope of practice, is **[included]** **identified** in the written agreement and is **[provided with the amount of supervision in keeping]** **consistent** with the accepted standards of medical practice.

(c) The physician assistant may pronounce death, **[but not]** **determine** the cause of death, and may authenticate with the physician assistant's signature any form related to pronouncing death. If the attending physician is not available, the physician assistant shall notify the county coroner. The coroner has the authority to release the body of the deceased to the funeral director.

(d) The physician assistant may authenticate with the physician assistant's signature any form that may otherwise be authenticated by a physician's signature as permitted by the supervising physician, **[State or Federal]** **Federal or State** law and facility protocol, if applicable.

(e) The physician assistant shall be considered the agent of the supervising physician in the performance of all practice-related activities including the ordering of diagnostic, therapeutic and other medical services.

§ 18.152. Prohibitions.

(a) A physician assistant may not:

(1) Provide medical services except as described in the written agreement.

(2) **[Prescribe or dispense drugs except as described in the written agreement]** **[Reserved]**.

(3) **[Maintain or manage a satellite location under § 18.155 (relating to satellite locations) unless the maintenance or management is registered with the Board]** **[Reserved]**.

(4) Independently practice **[or bill patients for services provided]**.

(5) Independently delegate a task specifically assigned to **[him]** **the physician assistant** by the supervising physician to another health care provider.

(6) **[List his name independently in a telephone directory or other directory for public use in a manner which indicates that he functions]** **Intentionally advertise as an independent practitioner or hold oneself out** as an independent practitioner.

(7) Perform acupuncture except as permitted by section 13(k) of the act (63 P.S. § 422.13(k)).

(8) **[Perform a medical service without the supervision of a supervising physician]** **[Reserved]**.

(b) A supervising physician may not:

(1) Permit a physician assistant to engage in conduct proscribed in subsection (a).

(2) Have primary responsibility for more than **[two]** **six** physician assistants **unless the Board approves supervision of additional physician assistants**.

§ 18.153. Executing and relaying medical regimens.

(a) A physician assistant may execute a written or oral order for a medical regimen or may relay a written or oral order for a medical regimen to be executed by a health care practitioner subject to the requirements of this section.

(b) **[As provided for in the written agreement, the physician assistant shall report orally or in writing, to a supervising physician, within 36 hours, those medical regimens executed or relayed by the physician assistant while the supervising physician was not physically present, and the basis for each decision to execute or relay a medical regimen]** **[Reserved]**.

(c) The physician assistant shall record, date and authenticate the medical regimen on the patient's chart at the time it is executed or relayed. When working in a **[medical care]** **health care** facility, a physician assistant may comply with the recordation requirement by directing the recipient of the order to record, date and authenticate that the recipient received the order, if this practice is consistent with the **[medical care]** **health care** facility's written policies. The supervising physician shall countersign the patient record **[within a reasonable time not to exceed 10 days, unless countersignature is required sooner by regulation, policy within the medical care facility or the requirements of a third-party payor]** **as provided for in the written agreement or as required under § 18.142(a)(5)(ii) (relating to written agreements)**.

(d) A physician assistant or **primary** supervising physician shall provide **[immediate]** access to the written agreement to anyone seeking to confirm the physician assistant's authority to relay a medical regimen or administer a therapeutic or diagnostic measure.

§ 18.154. Substitute supervising physician.

(a) If the primary supervising physician is **[unavailable]** **permanently unable** to supervise the physician assistant, the primary supervising physician may not delegate patient care to the physician assistant unless **[appropriate arrangements for substitute supervision are]** **at least one substitute supervising physician is named** in the written agreement and **[the substitute physician is registered as a supervising physician]** **on file** with the Board. **A list of all other substitute supervising physicians that the physician assistant may serve must be maintained at the physician assistant's practice location.**

(b) It is the responsibility of the substitute supervising physician to ensure that supervision is maintained in the absence of the primary supervising physician.

(c) During the period of supervision by the substitute supervising physician, the substitute supervising physician retains **[full professional and legal responsibility for the performance of]** **responsibility for the medical services that** the physician assistant **[and the care and treatment of the patients treated by the physician assistant]** **renders**.

(d) Failure to properly supervise may provide grounds for disciplinary action against the substitute supervising physician.

(e) In the event of the primary supervising physician becomes permanently unable to supervise, the substitute supervising physician shall assume primary responsibility for the physician assistant until a new written agreement can be filed for a time period not to exceed 30 days.

§ 18.155. **[Satellite locations]** **[Reserved]**.

[(a) *Registration of satellite location.* A physician assistant may not provide medical services at a satellite location unless the supervising physician has filed a registration with the Board.

(b) *Contents of statement.* A separate statement shall be made for each satellite location. The statement must demonstrate that:

(1) The physician assistant will be utilized in an area of medical need.

(2) There is adequate provision for direct communication between the physician assistant and the supervising physician and that the distance between the location where the physician provides

services and the satellite location is not so great as to prohibit or impede appropriate support services.

(3) The supervising physician shall review directly with the patient the progress of the patient's care as needed based upon the patient's medical condition and prognosis or as requested by the patient.

(4) The supervising physician will visit the satellite location at least once every 10 days and devote enough time onsite to provide supervision and personally review the records of selected patients seen by the physician assistant in this setting. The supervising physician shall notate those patient records as reviewed.

(c) *Failure to comply with this section.* Failure to maintain the standards required for a satellite location may result not only in the loss of the privilege to maintain a satellite location but also may result in disciplinary action against the physician assistant and the supervising physician.]

§ 18.156. Monitoring and review of physician assistant utilization.

(a) Representatives of the Board will be authorized to conduct scheduled and unscheduled onsite inspections of the locations where the physician assistants are utilized during the supervising physician's office hours to review the following:

(1) Supervision of the physician assistant. See §§ 18.144 and 18.154 (relating to responsibility of primary supervising physician; and substitute supervising physician).

(2) Presence of the written agreement and compliance with its terms. See § 18.142 (relating to written agreements).

(3) Utilization in conformity with the act, this subchapter and the written agreement.

(4) Appropriate identification of physician assistant. See § 18.171 (relating to physician assistant identification).

(5) Compliance with licensure and registration requirements. See §§ 18.141 and 18.145 (relating to criteria for licensure as a physician assistant; and biennial registration requirements; renewal of physician assistant license).

(6) Maintenance of records evidencing patient and supervisory contact by the supervising physician.

(b) **[Reports]** **Inspection reports** shall be submitted to the Board and become a permanent record under the supervising physician's registration. Deficiencies reported will be reviewed by the Board and may provide a basis for **[loss of the privilege to maintain a satellite location and]** disciplinary action against the physician assistant and the supervising physician.

(c) The Board reserves the right to review physician assistant utilization without prior notice to either the physician assistant or the supervising physician. It is a violation of this subchapter for a supervising physician or a physician assistant to refuse to comply with the request by the Board for the information in subsection (a).

(d) Additional inspections, including follow-up inspections may be conducted if the Board has reason to believe that a condition exists which threatens the public health, safety or welfare.

§ 18.157. Administration of controlled substances and whole blood and blood components.

(a) In a **[hospital, medical]** **health** care facility or office setting, the physician assistant may order or administer, or both, controlled substances and whole blood and blood components if the authority to order and administer these medications and fluids is expressly set forth in the written agreement.

(b) The physician assistant shall comply with the minimum standards for ordering and administering controlled substances specified in § 16.92 (relating to prescribing, administering and dispensing controlled substances).

§ 18.158. Prescribing and dispensing drugs, pharmaceutical aids and devices.

(a) *Prescribing, dispensing and administration of drugs.*

(1) The supervising physician may delegate to the physician assistant the prescribing, dispensing and administering of drugs and therapeutic devices.

(2) A physician assistant may not prescribe or dispense Schedule I controlled substances as defined by section 4 of The Controlled Substances, Drug, Device, and Cosmetic Act (35 P.S. § 780-104).

(3) A physician assistant may prescribe a Schedule II controlled substance for initial therapy, up to a 72-hour dose. The physician assistant shall notify the supervising physician of the prescription as soon as possible, but in no event longer than 24 hours from the issuance of the prescription. A physician assistant may write a prescription for a Schedule II controlled substance for up to a 30-day supply if it was approved by the supervising physician for ongoing therapy. The prescription must clearly state on its face that it is for initial or ongoing therapy.

(4) A physician assistant may only prescribe or dispense a drug for a patient who is under the care of the physician responsible for the supervision of the physician assistant and only in accordance with the **[supervising physician's instructions and]** written agreement.

(5) A physician assistant may request, receive and sign for professional samples and may distribute professional samples to patients.

(6) A physician assistant authorized to prescribe or dispense, or both, controlled substances shall register with the Drug Enforcement Administration (DEA).

(b) **[*Prescription blanks*]** ***Prescriptions***. The requirements for prescription blanks **and electronic prescriptions** are as follows:

(1) **[Prescription blanks]** **Prescriptions** must bear the license number of the physician assistant and the name of the physician assistant in a printed format at the heading of the **[blank]** **prescription**. The supervising physician must also be identified as required in § 16.91 (relating to identifying information on prescriptions and orders for equipment and service).

(2) The signature of a physician assistant shall be followed by the initials "PA-C" or similar designation to identify the signer as a physician assistant. When appropriate, the physician assistant's DEA registration number must appear on the prescription.

(3) The supervising physician is prohibited from presigning prescription blanks.

(4) The physician assistant may use a prescription blank generated by a **[hospital]** **health care facility** provided the information in paragraph (1) appears on the blank.

(c) *Inappropriate prescription.* The supervising physician shall immediately advise the patient, notify the physician assistant and, in the case of a written prescription, advise the pharmacy if the physician assistant is prescribing or dispensing a drug inappropriately. The supervising physician shall advise the patient and notify the physician assistant to discontinue using the drug and, in the case of a written prescription, notify the pharmacy to discontinue the prescription. The order to discontinue use of the drug or prescription shall be noted in the patient's medical record by the supervising physician.

(d) *Recordkeeping requirements.* Recordkeeping requirements are as follows:

(1) When prescribing a drug, the physician assistant shall keep a copy of the prescription, including the number of refills, in a ready reference file, or record the name, amount and doses of the drug prescribed, the number of refills, the date of the prescription and the physician assistant's name in the patient's medical records.

(2) When dispensing a drug, the physician assistant shall record the physician assistant's name, the name of the medication dispensed, the amount of medication dispensed, the dose of the medication dispensed and the date dispensed in the patient's medical records.

(3) **[The physician assistant shall report, orally or in writing, to the supervising physician within 36 hours, a drug prescribed or medication dispensed by the physician assistant while the supervising physician was not physically present, and the basis for each decision to prescribe or dispense in accordance with the written agreement]** **[Reserved]**.

(4) The supervising physician shall countersign the patient record **[within 10 days]** **as provided for in the agreement and as required under § 18.142(a)(5)(ii) (relating to written agreements)**.

(5) **[The]** **Upon request, the** physician assistant and the **primary** supervising physician shall provide **[immediate]** access to the written agreement to anyone seeking to confirm the physician assistant's authority to prescribe or dispense a drug. The written agreement must list the categories of drugs which the physician assistant is not permitted to prescribe.

(e) *Compliance with regulations relating to prescribing, administering, dispensing, packaging and labeling of drugs.* A physician assistant shall comply with §§ 16.92—16.94 (relating to prescribing, administering and dispensing controlled substances; packaging; and labeling of dispensed drugs) and Department of Health regulations in 28 Pa. Code §§ 25.51—25.58 (relating to prescriptions) and regulations regarding packaging and labeling dispensed drugs. See § 16.94 and 28 Pa. Code §§ 25.91—25.95 (relating to labeling of drugs, devices and cosmetics).

§ 18.159. Medical records.

The supervising physician shall timely review**[, not to exceed 10 days,]** the medical records prepared by the physician assistant to ensure that the requirements of § 16.95 (relating to medical records) have been satisfied **as described in the written agreement or as required under § 18.142(a)(5)(ii) (relating to written agreements)**.

[MEDICAL CARE FACILITIES] **HEALTH CARE FACILITIES** AND EMERGENCY MEDICAL SERVICES

§ 18.161. Physician assistant employed by **[medical]** **health** care facilities.

(a) A physician assistant may be employed by a **[medical]** **health** care facility, but shall comply with the requirements of the act and this subchapter.

(b) **[The physician assistant may not be responsible to more than three supervising physicians in a medical care facility]** **[Reserved]**.

(c) **[This subchapter does not require medical care facilities to employ physician assistants or to permit their utilization on their premises.]** Physician assistants are permitted to provide medical services to the **[hospitalized]** patients of their supervising physicians if the **[medical]** **health** care facility permits it.

(d) Physician assistants granted privileges by, or practicing in, a **[medical]** **health** care facility shall conform to policies and requirements delineated by the facility.

(e) In health care facilities, the attending physician of record for a patient shall act as the primary supervising physician for the physician assistant while the patient is under the care of the attending physician.

§ 18.162. Emergency medical services.

(a) A physician assistant may only provide medical service in an emergency medical care setting if the physician assistant has training in emergency medicine**[, functions within the purview of the physician assistant's]** **and is provided for in the** written agreement **[and is under the supervision of the supervising physician]**.

(b) A physician assistant licensed in this Commonwealth or licensed or authorized to practice in any other state who is responding to a need for medical care created by a declared state of emergency or a state or local disaster (not to be defined as an emergency situation which occurs in the place of one's employment) may render care consistent with relevant standards of care.

IDENTIFICATION AND NOTICE RESPONSIBILITIES

§ 18.171. Physician assistant identification.

(a) A physician assistant may not render medical services to a patient until the patient or the patient's legal guardian has been informed that:

(1) The physician assistant is not a physician.

(2) **[The physician assistant may perform the service required as the agent of the physician and only as directed by the supervising physician]** **[Reserved]**.

(3) The patient has the right to be treated by the physician if the patient desires.

(b) It is the supervising physician's responsibility to be alert to patient complaints concerning the type or quality of services provided by the physician assistant.

(c) In the supervising physician's office **[and satellite locations]**, a notice plainly visible to patients shall be posted in a prominent place explaining that a "physician assistant" is authorized to assist a physician in the provision of medical care and services. The supervising physician shall display the registration to supervise in the office. The physician assistant's license shall be prominently displayed at any location at which the physician assistant provides services. Duplicate licenses may be obtained from the Board if required.

(d) The physician assistant shall wear an identification tag which uses the term "Physician Assistant" in easily readable type. The tag shall be conspicuously worn.

§ 18.172. Notification of changes in employment.

(a) The physician assistant is required to notify the Board**[, in writing,]** of a change in or termination of employment or a change in mailing address within 15 days. Failure to notify the Board**[, in writing,]** of a change in mailing address may result in failure to receive pertinent material distributed by the Board. The physician assistant shall provide the Board with the new address of residence, address of employment and name of **the** registered **primary** supervising physician.

(b) The **primary** supervising physician is required to notify the Board**[, in writing,]** of a change or termination of supervision of a physician assistant within 15 days.

(c) Failure to notify the Board of changes in employment or a termination in the physician/physician assistant relationship is a basis for disciplinary action against the **primary supervising** physician's license, the **primary** supervising physician's registration and the physician assistant's license.

[Pa.B. Doc. No. 23-1754. Filed for public inspection December 15, 2023, 9:00 a.m.]

STATE BOARD OF MASSAGE THERAPY

[49 PA. CODE CH. 20]

Practice of Massage Therapy in Cosmetology or Esthetician Salons

The State Board of Massage Therapy (Massage Board) proposes to add §§ 20.61 and 20.62 (relating to definitions; and practice of massage therapy in cosmetology or esthetician salons) to read as set forth in Annex A.

Effective Date

This proposed rulemaking will be effective upon publication of final-form rulemaking in the *Pennsylvania Bulletin*.

Statutory Authority

The act of September 24, 2014 (P.L. 2476, No. 136) amended the act of May 3, 1933 (P.L. 242, No. 86) (63 P.S. §§ 507—527), referred to as the Cosmetology Law by adding section 9.3 (63 P.S. § 515.3) allowing for the practice of massage therapy within the licensed square footage of a cosmetology or esthetician salon. Section 9.3(d) of the Cosmetology Law requires the State Board of Cosmetology (Cosmetology Board) and the Massage Board to jointly promulgate final regulations to carry out the provisions of section 9.3.

Background and Purpose

Section 9.3(a) of the Cosmetology Law permits an individual licensed under the Massage Therapy Law (act) (63 P.S. §§ 627.1—627.50) to practice massage therapy within the approved premises of a licensed cosmetology salon or a licensed esthetician salon if: (1) the massage therapy licensee is the owner of or employed by the salon and is not an independent contractor; (2) the massage therapist practices in accordance with the Cosmetology Law and the act; (3) the salon owner provides an appropriate level of privacy for clients. Section 9.3(a)(3)(i) and (ii) of the Cosmetology Law provides that no physical barrier is required when the massage therapist is performing services that a cosmetologist or esthetician could perform; however, should the services exceed those within the scope of cosmetology or esthetics a separate room with permanent walls and doors must be utilized. Section 9.3(a)(3)(iii) of the Cosmetology Law further provides that an esthetician may provide services in the separate room that is designated for massage therapy services, so long as the cosmetologist or esthetician and massage therapist are not providing services concurrently.

Under section 9.3(b) of the Cosmetology Law, a licensee is subject to inspection by the Cosmetology Board and the Massage Board. A licensee who violates the Cosmetology Law or the act is subject to discipline by the licensee's applicable licensing board. Section 9.3 of the Cosmetology Law was effective on November 24, 2014, and immediately permitted the practice of massage therapy within the licensed square footage of a cosmetology or esthetician salon. The purpose of the Massage Board's joint regulations with the Cosmetology Board is to clarify standards for the practice of massage therapy in cosmetology or esthetician salons.

Prior to the enactment of section 9.3 of the Cosmetology Law, a patron wishing to receive services from a massage therapist and an esthetician would have to move from one room (a room considered not to be within the licensed square footage of the salon) to another room (a room considered to be within the licensed square footage of the salon) for each of the requested services. This process was found to be averse to the relaxing environment facilities were attempting to provide for their clients. The purpose of section 9.3 of the Cosmetology Law is to allow for the practice of massage therapy within the licensed square footage of a cosmetology or esthetician salon. With the enactment of section 9.3(a)(3)(iii) of the Cosmetology Law, a patron can receive massage therapy and esthetic services all within one room. This proposed rulemaking sets forth the requirements for practicing massage therapy in a cosmetology or esthetician salon. The Cosmetology Board is similarly proposing to update its regulations to clarify the standards for massage therapy in its salons and to ensure consistency between the standards of both boards.

Description of the Proposed Amendments

The Massage Board proposes to add §§ 20.61 and 20.62 to set forth the standards for practicing massage therapy within a cosmetology or esthetician salon under section 9.3 of the Cosmetology Law.

Section 20.61 defines the terms "Cosmetology Law" and "salon," in relation to § 20.62. Section 20.62(a) sets forth the conditions that must be met to practice massage therapy within a cosmetology or esthetician salon, as required by section 9.3(a) of the Cosmetology Law. Subsection (a)(1) states that a massage therapist must be the

owner of the salon or an employee, not an independent contractor, as required by section 9.3(a)(1) of the Cosmetology Law.

Subsection (a)(2) requires that a salon owner provide an appropriate level of privacy for clients. Subsection (a)(2)(i)(A) and (B) clarifies that when a massage therapist is practicing in a separate massage therapy room of the salon, or in the areas of the salon used for cosmetology or esthetics, the massage therapist is practicing in the licensed square footage of the salon. Furthermore, subsection (a)(2)(i)(A) and (B) provides clarification as to what services require a separate massage therapy room by specifically listing the massage services that do not require the use of physical barriers. The Massage Board's proposed rulemaking reflects section 9.3(a)(3)(i) of the Cosmetology Law which provides that no physical barriers separating the areas used for massage therapy from the areas used for cosmetology or esthetics, as defined in section 1 of the Cosmetology Law (63 P.S. § 507), shall be required when a massage therapist performs massage services that a cosmetologist or esthetician is authorized to perform. Subsection (a)(2)(ii) clarifies that when a massage therapist is practicing in a separate massage therapy room of the salon, the massage therapist is practicing in the licensed square footage of the salon. Furthermore, subsection (a)(2)(ii) requires that a salon owner provide separate massage therapy rooms with permanent walls and doors to ensure privacy for clients receiving massage services from a massage therapist when the services are beyond the practice of cosmetology or esthetics, as required by section 9.3(a)(3)(i) of the Cosmetology Law.

Subsection (a)(2)(ii)(A)—(C) sets forth standards for separate massage therapy rooms. Subsection (a)(2)(ii)(A) requires that massage therapy rooms be a minimum of 120 square feet in size, which is a generally accepted industry standard based on the size of a standard massage table (73 inches × 30 inches) and allows room for a massage therapist to safely maneuver around it (approximately 3 to 4 feet on each side of the table). The Massage Board feels this requirement is necessary because § 7.76(a) (relating to floor space) of the Cosmetology Board's regulations provide "[a]n additional area of at least 60 square feet is required for each additional licensee in the salon." Accordingly, it is likely that salon owners unfamiliar with the practice of massage therapy will expect massage therapists to perform massage therapy in rooms designed for the practice of cosmetology or esthetician services (that is, rooms with little more than 60 square feet in size). A 60-square-foot room does not provide a massage therapist sufficient room to safely maneuver around a standard-sized massage table and keep the necessary supplies at hand. Additionally, massage therapy clients are often asked to position their arms at a 90-degree angle to the body, and the massage therapist must safely maneuver around the client's outstretched arms. Moreover, clients are typically expected to use the massage therapy room to disrobe and transition to the massage therapy table. Accordingly, massage therapy rooms frequently include a chair, as well as clothing storage such as clothing hooks or a shelving unit. It would be a safety risk to expect a massage therapist to safely perform massage therapy multiple times a day in any room smaller than 120 square feet. Accordingly, after discussing this issue at public board meetings, and reaching an agreement with the Cosmetology Board, the Massage Board is of the opinion that a minimum room size of 120 square feet is appropriate.

Subsection (a)(2)(ii)(B) discusses the storage of linens or other supplies used by a massage therapist in a salon. Cosmetology Board regulations in §§ 7.71a—7.71c (relating to equipment and supplies for an esthetician salon; equipment and supplies for a nail technology salon; and equipment and supplies for a natural hair braiding salon) set minimum standards for equipment and supplies, detailing what must be available to licensees/certificate holders and where linens must be stored. Being that massage therapists working in salons will be required to adhere to both Massage Board regulations and Cosmetology Board regulations, the Massage Board believes that it must clarify where massage therapists may store linens and other supplies. Accordingly, subsection (a)(2)(ii)(B) allows the massage therapist to store linens or other supplies used for massage therapy in the massage therapy room or in the salon in a space designated by the salon owner.

Subsection (a)(2)(ii)(C) states esthetician services may be provided in the massage therapy room, so long as esthetician services were not provided concurrent to the massage therapy services, as required by section 9.3(a)(3)(iii) of the Cosmetology Law.

Subsection (b) requires a massage therapist practicing massage therapy within the approved premises of a salon to practice in accordance with the Massage Board's regulations, the act and the Cosmetology Law, as required by section 9.3(a)(2) of the Cosmetology Law.

Subsection (c) states that a massage therapist practicing in accordance with section 9.3 of the Cosmetology Law would be subject to inspection by both the Massage Board and Cosmetology Board, as required by section 9.3(b) of the Cosmetology Law.

Subsection (d) states that a massage therapist practicing in a salon, who violates the Cosmetology Law or the Massage Therapy Law, is subject to discipline by the Massage Board, as required by section 9.3(c) of the Cosmetology Law.

Fiscal Impact and Paperwork Requirements

There will be no unnecessary negative fiscal impact on licensees or the Massage Board. Section 9.3 of the Cosmetology Law permits the practice of massage therapy within the licensed square footage of a cosmetology or esthetician salon as of November 24, 2014. The Massage Board does not track how many massage therapists work in salons. Furthermore, the Massage Board does not track how many massage therapists may be working in rooms smaller than required in this proposed rulemaking. However, it is unlikely that any significant number of massage therapists have been practicing in rooms smaller than 120 square feet because the practice of massage therapy in a room smaller than 120 square feet would be difficult and potentially dangerous. Furthermore, 120 square feet is a generally accepted minimum industry standard based on the size of a standard massage table (73 inches × 30 inches) and allowing room for a massage therapist to safely maneuver around it (approximately 3 to 4 feet on each side of the table). However, the small number of massage therapists who may be currently working in rooms smaller than 120 square feet will have to comply with the proposed regulation. For the reasons explained in this preamble, it is in the public interest to require that massage therapy be performed in a room large enough to accommodate all that is required.

Sunset Date

The Massage Board continuously monitors the effectiveness of its regulations on a fiscal year and biennial basis. Therefore, no sunset date has been assigned.

Regulatory Review

Under Section 5(a) of the Regulatory Review Act (71 P.S. § 745.5(a)), on December 4, 2023, the Massage Board submitted a copy of this proposed rulemaking and a copy of a Regulatory Analysis Form to the Independent Regulatory Review Commission (IRRC) and to the chairperson of the Consumer Protection and Professional Licensure Committee of the Senate and the chairperson of the Professional Licensure Committee of the House of Representatives. A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, IRRC may convey comments, recommendations or objections to the proposed rulemaking within 30 days of the close of the public comment period. The comments, recommendations or objections shall specify the regulatory review criteria that have not been met. The Regulatory Review Act specifies detailed procedures for review, prior to final publication of the rulemaking, by the Commissioner, the General Assembly and the Governor.

Public Comment

Interested persons are invited to submit written comments, suggestions or objections regarding this proposed rulemaking to the Regulatory Counsel, Department of State, P.O. Box 69523, Harrisburg, PA 17106-9523 or RA-STRegulatoryCounsel@pa.gov, within 30 days following publication of this proposed rulemaking in the *Pennsylvania Bulletin*. Comments should be identified as pertaining to rulemaking 16A-726 (massage therapy in cosmetology or esthetician salons).

NANCY M. PORAMBO, LMT,
Chairperson

Fiscal Note: 16A-726. No fiscal impact; recommends adoption.

Annex A

TITLE 49. PROFESSIONAL AND VOCATIONAL STANDARDS

PART I. DEPARTMENT OF STATE

Subpart A. PROFESSIONAL AND OCCUPATIONAL AFFAIRS

CHAPTER 20. STATE BOARD OF MASSAGE THERAPY

PRACTICE OF MASSAGE THERAPY IN COSMETOLOGY OR ESTHETICIAN SALONS

(*Editor's Note*: Sections 20.61 and 20.62 are proposed to be added and are printed in regular type to enhance readability.)

§ 20.61. Definitions.

The following words and terms, when used in this section and § 20.62 (relating to practice of massage therapy in cosmetology or esthetician salons), have the following meanings, unless the context clearly indicates otherwise:

Cosmetology Law—The act of May 3, 1933 (P.L. 242, No. 86) (63 P.S. §§ 507—527), referred to as the Cosmetology Law.

Salon—A cosmetology salon or esthetician salon licensed by the State Board of Cosmetology in accordance with the Cosmetology Law.

§ 20.62. Practice of massage therapy in cosmetology or esthetician salons.

(a) A massage therapist licensed under the act is permitted to practice massage therapy within the approved premises of a salon if all of the following conditions are met:

(1) The massage therapist is the owner of or employed by the salon and is not an independent contractor.

(2) The salon owner provides an appropriate level of privacy for clients in accordance with all of the following:

(i) *Massage therapy services within the scope of practice of the Cosmetology Law.* When a massage therapist is practicing in a separate massage therapy room of the salon, or in the areas of the salon used for cosmetology or esthetics, the massage therapist is practicing in the licensed square footage of the salon. Physical barriers separating the areas used for massage therapy services from the areas used for cosmetology or esthetics are not required when a massage therapist provides massage therapy services that are within the scope of practice of cosmetology as defined in § 7.1 (relating to definitions) as follows:

(A) Massage therapy services of the scalp, face, arms or hands, or the upper part of the body.

(B) Massage therapy services of the feet or the lower legs of an individual up to the individual's knee.

(ii) *Massage therapy services beyond the scope of practice of the Cosmetology Law.* When a massage therapist is practicing in a separate massage therapy room of the salon, the massage therapist is practicing in the licensed square footage of the salon. A salon owner shall provide separate massage therapy rooms with permanent walls and doors to ensure privacy for clients receiving massage therapy services from a massage therapist when the massage therapy services are beyond the scope of practice of cosmetology or esthetics as provided in § 7.1. The following apply:

(A) The size of the separate massage therapy room must be a minimum of 120 square feet.

(B) The massage therapist may store linens or other supplies in the separate room provided or in the salon in a space designated by the salon owner.

(C) Esthetician services may be provided to a client in the same room where the client receives massage therapy, provided these services are not performed concurrently.

(b) A massage therapist providing massage therapy services within the approved premises of a salon shall practice in accordance with this chapter, the act and the Cosmetology Law.

(c) A massage therapist providing massage therapy services within the approved premises of a salon is subject to inspection by the State Board of Cosmetology and the board.

(d) A massage therapist providing massage therapy services within the approved premises of a salon who violates this section, the act or the Cosmetology Law is subject to discipline by the board.

[Pa.B. Doc. No. 23-1755. Filed for public inspection December 15, 2023, 9:00 a.m.]