A comprehensive look at the legislative issues affecting advanced nursing practice

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Director of Government Relations, California Association of Nurse Practitioners

So often, our professional meetings are mired in discussions of what practice authority nurse practitioners (NPs) don’t have and the barriers of practice that still exist. Members are given open forum to discuss and inquire about issues they would like to see addressed, which vary from state to state. The global theme that emerges during all of these sessions is that associations, organizations, and agencies are not doing enough to change the practice landscape for providers who are on the front lines. This article will highlight the practice authority of NPs across the nation, focusing on the practice authority that NPs do possess.

The United States is unique in that, although advanced practice nursing (APN) varies from state to state as defined by individual state law, the national NP organizations are working every day to improve the practice of NPs nationwide. National organizations are able to impact NP practice from a global perspective and where federal policy change is required. The national organizations also remain
in a position to influence statutory change at the state level.

Nurse practitioner practice in the United States is better now than it was last year, and the year before that, and 5 years ago, and so on. Nurse practitioners nationwide have been successful in scientifically demonstrating their contribution to healthcare. Access to healthcare has improved dramatically because of the emergence and advancement of NP practice and will continue to do so at an accelerated rate. It is thrilling to review the legislative accomplishments in preparation for this annual report. Nurse practitioners are on the same page, and continue to move forward in legal authority to practice, reimbursement for services, and prescriptive authority.

Nurse practitioners are part of the healthcare team. According to Webster’s II New Riverside University Dictionary, “collaboration” means, “to work together, especially in a joint intellectual effort.” Optimal patient care comes when members of the healthcare team collaborate to provide the best possible healthcare to a patient. Nurses, and thereby NPs, are leaders in collaboration, working with all healthcare team members who contribute to the ultimate well-being and care of a patient.

Eighteen states have successfully passed laws or drafted regulations removing practice barriers for NP practice and other APN practice. This report divides updates into three categories: Legal Authority, Reimbursement, and Prescriptive Authority. A new category, Legislative Accomplishments, highlights specific legislation passed in 2005. Information contained within the following state updates was generously provided by each state’s Board of Nursing (BON) and the professional organizations responsible for, or who contribute to, the advancement of NP practice through legislative activity.

**Legal Authority**

Arizona’s BON revised rules and regulations by defining Advanced Practice Registered Nurses’ (APRNs), in addition to clarification of Registered Nurse Practitioners’ (RNP’s) scope of practice and the need for collaboration on an “as-needed” basis. Florida’s BON has proposed rules to require national certification for new applicants after July 1, 2006 and to approve graduates of doctoral level NP programs. Indiana reported that a law was passed granting APNs and other providers immunity from civil or criminal liability who make a good faith report to the bureau concerning a patient’s fitness to operate a motor vehicle not more than 30 days after having examined the patient. Louisiana passed HB 158, Act 200, authorizing NPs to sign school excuses. New Hampshire is celebrating the passage of a bill that added “scope of practice” language to the Nurse Practice Act for all types of licensees, including advanced registered nurse practitioners (ARNPs). Additionally, the Joint Health Council adopted new definitions for “Collaboration” and “Consultation” within the official ARNP exclusionary drug formulary. Nebraska passed legislation defining APRNs and creating a separate APRN Board to regulate their practice. This bill also allows for the licensure of clinical nurse specialists (CNSs) in Nebraska. New Jersey passed legislation authorizing APNs to perform examinations and certify temporary disability. Ohio’s NPs gained title protection by defining APNs as a CNP, certified registered nurse anesthetist (CRNA), certified nurse midwives, and certified registered nurse anesthetists. See “Summary of Advanced Practice Nurse Population” for details.

**Summary of Advanced Practice Nurse (APN) Legislation: Legal Authority for Scope of Practice**

| States with nurse practitioner* title protection; the board of nursing has sole authority in scope of practice, with no statutory or regulatory requirements for physician collaboration, direction, or supervision: AK, AR, AZ, CO, DC, HI, IA, ID, KS, KY, ME, MI, MT, ND, NH, NJ, NM, OK, OR, RI, TN, TX, UT, WA, WI, WV, WY |
| States with nurse practitioner* title protection; the board of nursing has sole authority in scope of practice, but scope of practice has a requirement for physician collaboration: CT, DE, IL, IN, IA, MD, MN, MO, NE†, NV, NY, OH, PA, VT |
| States with nurse practitioner* title protection; the board of nursing has sole authority in scope of practice, but scope of practice has a requirement for physician supervision: CA, FL, GA, MA, SC |
| States with nurse practitioner* title protection, but the scope of practice is authorized by the board of nursing and the board of medicine: AL, MS, NC, SD, VA |

*This table provides a state-by-state summary of the degree of independence for all aspects of NP scope of practice, including diagnosing and treating (except prescribing). See Table: “Summary of APN Legislation: Prescriptive Authority” for a state-by-state analysis of NP prescriptive authority.

**This information may apply to other APNs (clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists). See “Summary of Advanced Practice Nurse Population” for details.

† State with APRN Board.

www.tnpj.com
Summary of APN Legislation: Prescriptive Authority*

- States where nurse practitioners** can prescribe (including controlled substances) independent of any required physician involvement in prescriptive authority: AK, AZ, DC, IA, ID, ME, MT, NH, NM, OR, UT‡, WA, WI, WY.
- States where nurse practitioners** can prescribe (including controlled substances) with some degree of physician involvement or delegation of prescription writing: AR, CA, CO, CT, DE, GA‡, HI, IL, IN, KS, LA, MA, MD, MI, MN, MS, NC, ND, NE, NJ, NV, NY, OH, OK, PA, RI, SC, SD, TN, TX, VA, VT, WV.
- States where nurse practitioners** can prescribe (excluding controlled substances) with some degree of physician involvement or delegation of prescription writing: AL, FL, KY, MO.

All states: Nurse practitioners** may receive and/or dispense drug samples based on authorized scope of practice, rules and regulations, or statutes.

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* This table provides a state-by-state analysis of NP prescriptive authority. For analysis of other aspects of the NP scope of practice (including diagnosing and treating), see Table: “Summary of APN Legislation: Legal Authority for Scope of Practice.”

** The information may apply to other APNs (clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists). See “Summary of Advanced Practice Nurse Population” for details.

† Schedule IV and/or V controlled substances only.

‡ Nurse practitioners do not have written prescribing or dispensing authority; the process falls under delegated medical authority.

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wives to practice while their collaborative agreements are being reviewed by the Board of Nursing and Board of Medicine. Oregon passed a Nurse Practitioner Omnibus Bill, amending several code sections to include NP language. Pennsylvania’s NPs are now legally authorized to collaborate with an osteopathic physician, in addition to a medical physician. Texas put forth “provider-neutral” language in nine separate bills this legislative session. One of the bills establishes a pilot healthcare clinic in a state office staffed by an NP. Utah’s Governor vetoed a bill passed by the legislature making it illegal for school employees, including APRNs and RNs, to make certain medical recommendations to parents about their child’s health status, including recommending a psychiatric evaluation and psychotropic drugs. Utah also passed the Direct Entry Midwife Act, authorizing the licensing of Direct Entry Midwives who are not CNMs.

Reimbursement

Texas passed a Medicaid Reform Bill requiring APNs to be primary care providers (PCPs). Provisions are included that require managed care companies who provide healthcare for Medicaid clients to include APNs as PCPs.

Prescriptive Authority

Florida passed legislation authorizing NPs and physician assistants to prescribe Home Health Services and to write care plans. Hawaii reported the Joint Formulary Advisory Committee of the Department of Commerce and Consumer Affairs submitted a formal written report to the Legislature on its activities and recommendations with respect to the prescriptive authority formulary for APRNs. In this report, the committee recommended that APRNs with prescriptive authority be allowed to prescribe controlled substances Schedules II-V with a supervisory relationship with a physician. Maine obtained full prescriptive authority, including controlled substances Schedules II-V. New Jersey’s BON has drafted regulations pertaining to APN prescribing of controlled substances. These include a 6-hour controlled substances prescribing course and amendment of their joint protocol to include the initiation of controlled substance medications. Oregon passed a law allowing CNSs to obtain prescriptive authority, including Schedules II-V controlled substances. South Carolina reported that the BON asked the Drug Enforcement Administration to clarify that only APRNs who prescribe controlled substances Schedules III-V will be required to obtain a Drug Enforcement Administration number. Washington announced the passage of a bill that eliminates the requirement for collaboration and a Joint Practice Agreement with a physician to prescribe controlled substances. Additionally, this law eliminated the prohibition of CRNAs from prescribing controlled Schedules II-V.

In addition, The Idaho BON is considering adoption of the National Council of State Boards of Nursing APN Compact.

The Work Continues

Advanced practice nurses are compassionate and strong members of the healthcare team. As we begin to unite as professionals, we are strengthening our worth in the eyes of the public and our medical cohorts. As our story of courage and goal of complete autonomy press into 2006, we renew our purpose to make high-quality patient care our top priority.

The Nurse Practitioner staff would like to extend our sincere appreciation for the input of the State Boards of Nursing and professional nursing organizations that provided the information for this report.

continued on p. 11
The drug maintained its blood pressure-lowering effect through dosing.

### Summary of Advanced Practice Nurse Population*

<table>
<thead>
<tr>
<th>State</th>
<th>Total Number of Advanced Practice Nurses</th>
<th>Nurse Practitioners</th>
<th>Clinical Nurse Specialists</th>
<th>Certified Nurse Midwives</th>
<th>Certified Registered Nurse Anesthetists</th>
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<td><strong>15,098</strong></td>
<td><strong>10,599</strong></td>
<td><strong>32,987</strong></td>
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* Numbers are provided by state BON authorities. The numbers may include duplicate licenses within one state or multistate licensure. The numbers reflect state APN recognition only and may not reflect active employment status.

** Not specialty-identified, certified, or licensed as an APN; not officially tracked by the state BON.

† Psychiatric specialty only.

‡ Specialty is included in total of APNs, but not counted separately.

§ Specialty is not included in total of APNs.
Alabama

http://www.abn.state.al.us

Legal Authority

The BON has sole authority to establish the qualifications and certification requirements of APNs through R&Rs. CNSs and CRNAs are not regulated by the joint committee (BON and BOME), and are not eligible for prescriptive authority. APNs are defined as CRNPs, CNMs, CRNAs, and CNSs. The BON and BOME regulate (through R&R) the collaborative practice of physicians and CRNPs and CNMs and require them to practice with BON- and BOME-approved protocols. The collaborating physician and NP or CNM practicing with the physician must sign the protocol. “The term ‘collaboration’ does not require direct, on-site supervision of the activities of a CRNP or CNM by the collaborating physician. The term does require such professional oversight and direction as may be required by the R&R of the BON as may be required.” The collaborating physician shall be present in a practice site a minimum of 10% per month (if the CRNP’s or CNM’s collaboration time is 30 or more hours per week) and a minimum of 10% on a quarterly basis (if the collaboration time is less than 30 hours per week). The APN shall practice in accordance with national standards and functions identified by the appropriate specialty-certifying agency and as congruent with Alabama law. CRNP scope of practice is defined in statute and regulation. Alabama does not recognize APNs as “primary care providers” and does not have “any willing provider” language in statute. CRNPs are required to have an MSN and national certification on entry into practice, with a few exceptions: initial CRNP applicants are exempt from requirement for MSN on discretion of the BON if graduation was prior to 1996 in a post-BSN NP program, or graduation prior to 1984 from a non-BSN program preparing NPs. CRNAs must have a minimum of a master’s degree from an accredited nurse anesthesia graduate program and be currently certified as a CRNA; CRNAs who graduated prior to December 31, 2003, are exempt from the master’s degree requirement. CNS approval requires MSN as a CNS and national certification.

Reimbursement

There are no legislative restrictions against APNs on managed care panels. The Alabama Medicaid Nurse Practitioner Program reimburses NPs; Alabama Medicaid does not reimburse CRNPs and CNMs may “prescribe, administer, and provide therapeutic tests and drugs” excluding Schedules II–V controlled substances, within an approved formulary. A BON and BOME joint committee (composed of one CNM, CRNP, and RN and three physicians) recommends R&R governing the collaborative relationship between physicians and CRNPs and CNMs and the prescription of legend (noncontrolled) drugs. The R&Rs limit the physician to three full-time equivalent (FTE) CRNPs (120 hours weekly) without limit on the number of CRNPs. The physician is limited to four CNMs per three FTEs. Exemptions to this specification include public health employees and practices in place before the R&Rs took effect. The joint committee considers applications for ratio exemptions. The BON and BOME shall approve the protocols and formulary of legend drugs that may be prescribed by authorized CRNPs and CNMs. Authorization is tied to the collaborative agreement; if CRNPs or CNMs change physicians, they must reapply. The CRNP or CNM is issued a 4-digit Rx number by the BON; the Rx pad must include the physician name and address and the CRNP or CNM name, RN license number, and Rx number. The CRNP or CNM who is in collaborative practice and has Rx privileges may sign for and dispense approved formulary drugs. The physician must notify the BOME in writing within 5 days of commencing or terminating a collaborative agreement with a CRNP or CNM. CNSs and CRNAs are not regulated by the joint committee (BON and BOME), and are not eligible for prescriptive authority.

Alaska

http://www.dced.state.ak.us/occ/pnur.htm

2005 Legislative Accomplishments

The passage of Senate Bill 22 (Davis, et al) added birthing centers to the list of healthcare facilities eligible for payment of medical assistance for needy persons. For more information, log on to http://w3.legis.state.ak.us/home.htm.

Legal Authority

APNs are regulated by the Alaska BON. APNs include NPs and CNMs and are defined as an RN who, because of specialized education and experience, is certified to perform acts of medical diagnosis and prescription, as well as dispense medical, therapeutic, or corrective measures under regulations adopted by the BON. Regulations require that an APN must have a plan for patient consultation and referral, but a physician relationship is not required. SOP for APNs is not directly defined in statute or regulation, however, regulation refers to the national certifying body for definition of SOP in specialty areas. APNs in Alaska are statutorily recognized as “primary care providers.” Nothing in the law precludes admitting privileges for ANPs; however, hospitals require a physician preceptor with the exception of the Federal Alaska Native Hospital. Entry into NP practice requires a master’s degree in nursing and national board certification. Continuing education requirements for ANPs are 30 CEUs (8 of these must be Rx hours) every 2 years. CRNAs practice under separate rules and regulations, and CNSs are not licensed or recognized separately from their RN license.

Legislative Update Key

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<th>Field</th>
<th>Type</th>
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<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<td>ANP</td>
<td>Advanced Nurse Practitioner</td>
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<td>Advanced Practice Nurse</td>
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<td>FNP</td>
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</tr>
<tr>
<td>GNP</td>
<td>Geriatric Nurse Practitioner</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>JPC</td>
<td>Joint Practice Committee</td>
</tr>
<tr>
<td>LVN</td>
<td>Licensed Vocational Nurse</td>
</tr>
<tr>
<td>NA</td>
<td>Nurse Anesthetist</td>
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<tr>
<td>NPA</td>
<td>Nurse Practice Act</td>
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<td>PCP</td>
<td>Primary Care Provider</td>
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<td>PNP</td>
<td>Pediatric Nurse Practitioner</td>
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<td>PPO</td>
<td>Preferred Provider Organization</td>
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<tr>
<td>PT</td>
<td>Physical Therapist</td>
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<tr>
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<td>Occupational Therapist</td>
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<tr>
<td>Rx</td>
<td>Pharmacology/Prescriptive/Prescribe</td>
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<tr>
<td>SOP</td>
<td>Scope of Practice</td>
</tr>
<tr>
<td>WHNP</td>
<td>Women’s Health Nurse Practitioner</td>
</tr>
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</table>

• Certification (by a nationally recognized accrediting agency for this specialty)

• For each state’s Medicare carrier, access the CMS Web site: http://cms.hhs.gov/providers/enrollment/contracts/
Reimbursement

All healthcare in Alaska is provided on a fee-for-service basis; managed care does not exist. FNPs, PNPs, and CNMs are authorized by law to receive Medicaid reimbursement; NPs receive 80% of the physicians’ payment. A nondiscriminatory clause in the insurance law allows for third-party reimbursement to NPs, however, the BC/BS federal plan charges patients a $200 deductible to see NPs. This plan does not charge a deductible to see a physician. Alaska legally requires insurance companies to credential, empanel, and/or recognize ANPs. Alaska does not have “any willing provider” language in current law.

Prescriptive Authority

Authorized NPs and CRNAs have independent prescriptive authority, including Schedules II-V controlled substances, and may apply for DEA registration. They are legally authorized to request, receive, and dispense pharmaceutical samples in Alaska. The Alaska Nurses Association reports that problems have been documented with pharmacy warehouses refusing to fill prescriptions written by APNs. Prescriptions are labeled with the APN’s name only. Continuing education credits (30) are required for renewal of licensure (8 of which must be in Rx) every 2 years.

Legal Authority

The Arizona BON grants APRNs authority and regulates their practice. APRNs are defined as an RN, which includes NPs, CNMs, and CNSs. According to the BON, recent changes to RNP regulations state that an RNP will refer a patient to a physician or other healthcare provider if a situation or condition occurs in a patient that is beyond the RNP’s knowledge and experience. No formal collaboration agreement is required. RNP SOP is defined in regulation R4-19-507. RNPs are not statutorily recognized as “primary care providers”; however, they are legally authorized to hold admitting and hospital privileges through R&Rs. RNPs must have a master’s degree in nursing and national certification to enter into practice.

Reimbursement

RNPs and other certified RNs receive third-party reimbursement, enabled by the Department of Insurance statutes. There is no Medicaid; the Arizona Health Care Cost Containment System (AHCCCS) contracts with PCPs on a capitated basis. Some NPs have directly contracted with AHCCCS as PCPs. AHCCCS NP reimbursement is 90% of the established physician rate.

Prescriptive Authority

RNPs have full prescriptive and dispensing authority, including controlled substances Schedules II-V, on application and fulfillment of BON-established criteria. RNPs’ prescriptive and dispensing authority is linked to the RNP’s SOP (e.g., according to the BON, prescribing to an adult is outside of a PNP’s SOP). Prescribing without documenting an examination is considered by the BON to be a violation of the NPA. An RNP with prescriptive and dispensing authority who wishes to prescribe a controlled substance must apply to the DEA for a registration number and file this number with the BON. Drugs, other than controlled substances, may be refilled up to 1 year. CRNAs may prescribe drugs to be administered by a licensed certified or registered healthcare provider preoperatively, postoperatively, or as part of a procedure; CRNAs are not authorized to dispense.

Arkansas

http://www.arnma.org/

2005 Legislative Accomplishments

None to report at time of print, however, Arkansas is working on Medicaid reimbursement for all APN specialties and “any willing provider” language with third-party insurance payers.

Legal Authority

The BON grants APNs authority to practice via second licensure, separate from RN licensure. APNs are licensed and defined as an NP, CNM, CNS, or CRNA. Physician collaboration/supervision is not required for APNs with the exception of NPs who are not nationally certified. NPs who are not nationally certified qualify for licensure as an RNP; however, they must practice under physician direction/protocol. R&R provide for SOP as defined by the national certifying body. Hospital privileges for APNs are determined on a hospital-to-hospital basis according to the credentialing committee of each hospital. Graduate-level APN education is required for initial APN licensure; however, there are provisions for licensure by endorsement for APNs without graduate degrees.

Reimbursement

The NPA mandates direct Medicaid reimbursement to APNs and RNPs with the exception of adult, acute care, and psychiatric/mental health NPs. Medicaid reimbursement is 80% of a physician’s rate. APNs are not recognized as PCPs for Medicaid. Although collaborative practice is not legally required for APNs to practice, BC/BS will only reimburse APNs who have a collaborative practice agreement with a physician. Services are filed under the collaborative physician’s name and are paid at the physician’s rate. Reimbursement is limited to Evaluation and Management Codes 99203 and 99213 and below. CNMs and some NPs are listed on managed care panels. A statutory provision exists for third-party reimbursement for CRNAs.

Prescriptive Authority

The NPA authorizes the BON to provide a certificate of prescriptive authority, including Schedules III-V controlled substances, to qualified APNs in collaborative practice with a physician of comparable specialty/scope and using protocols for prescribing. Neither protocols nor collaborative practice agreements with a physician are required unless the APN has prescriptive authority. Under R&R, an initial application for Rx authority must (1) be an APN with completion of pharmacology course work of 3 graduate credit hours or 45 contact hours in a competency-tested pharmacology course; (2) have 300 hours of precepted prescribing experience; and (3) include a collaborative practice agreement with a physician. Endorsement applicants must provide Rx evidence of at least 500 hours in the last year and have a clear DEA history. APNs who have fulfilled requirements for prescriptive authority may receive pharmaceutical samples and therapeutic devices appropriate to their area of practice, including Schedules III-V controlled substances. APNs with prescriptive authority have implied authority to give sample Rx drugs to patients.

California

http://www.rn.ca.gov/
http://www.canpweb.org

2005 Legislative Accomplishments

CNMs were successful in the passage of SB 614 (Figueroa), which grants CNMs authority to furnish Schedule II controlled substances outside of the acute care setting (i.e., birthing centers).

Legal Authority

The California Board of Registered Nursing (BRN) grants legal authority to practice, and regulates and issues separate certification to NPs, CNMs, CRNAs, and CNSs. Advanced practice titles are legally protected and defined as APNs. California is a supervisory state; however, “supervision” does not require the physical presence of a physician. NP’s function under “standardized procedures” or protocols when performing medical functions,
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which are collaboratively developed and approved by the NP, physician, and administration in the organized healthcare facility in which they work. The SOP of an NP is defined within standardized procedures, which are defined in regulation. NPs and CNMs are statutorily recognized as “primary care providers” in California’s Medi-Cal system. APNs are not legally authorized to admit patients to the hospital; however, individual hospitals may grant hospital privileges to APNs. NPs entering practice after January 1, 2008, must have a master’s degree to practice; however, California does not require national certification to practice.

Reimbursement

Medi-Cal (California’s Medicaid program) reimburses family NPs, pediatric NPs, CNMs, and CRNAs for Medicaid-covered services at the same rate as physicians. Blue Cross of CA Medi-Cal Provider Directory lists NPs as PCPs under their area specialty. There is no legal preclusion to third-party reimbursement of services; however, policies vary from payer to payer. Third-party payers are legally required, however, to reimburse BRN-listed psychiatric-mental health nurses for qualifying services. Participants in the state’s managed care programs for specified Medi-Cal beneficiaries may select NPs and CNMs as their PCPs.

Prescriptive Authority

NPs and CNMs may furnish or “order” drugs or devices, including Schedules II–V controlled substances when the drugs or devices are furnished or ordered by an NP or CNM in accordance with standard procedures. The act of “furnishing” is legally the same as the act of prescribing. Prescriptions are labeled with the NP’s or CNM’s name only. NPs and CNMs may request, receive, and dispense pharmaceutical samples and may dispense drugs, including controlled substances pursuant to a standardized procedure or protocol. NPs and CNMs authorized by the BRN to furnish controlled substances must register for a DEA number. To obtain a DEA-issued furnishing number, NPs and CNMs must complete a 45-hour qualifying pharmacology course and 520 hours of physician-supervised experience post-certification.

Colorado

http://www.dora.state.co.us/nursing

Legal Authority

The Colorado BON grants APNs legal authority to practice and also regulates their practice. Title protection is provided to APNs, defined as NPs, CNSS, and CRNAs. Use of APN titles requires BON registration. NPs can be admitted to the Advanced Practice Nurse Registry upon successful completion of a nationally accredited education program for preparation as an APN or a passing score on a certification exam of a nationally recognized accrediting agency. Colorado requires APNs to have a collaborative agreement with a physician for prescriptive privileges only. The collaborative agreement will include duties and responsibilities of each party, provision regarding consultation and referral, and a mechanism designed by the APN to ensure appropriate prescriptive practice. CNMs shall have “a safe mechanism for consultation or collaboration with a physician or, when appropriate, referral to a physician.” APN SOP is founded on the relevant educational program and core curriculum as determined by acceptable professional standards. Although a function may be within an APN’s scope, the individual APN must have the requisite knowledge, judgment, and skill to safely and competently perform any undertaken function. APNs are not statutorily recognized as “primary care providers;” however, they are not legally prohibited from being PCPs. Currently, APNs may hold hospital privileges, but interpretation of a ruling states that APNs may not admit patients to the hospitals. After July 1, 2008, a graduate degree in a nursing specialty will be the minimum degree requirement to enter into practice. Current law states that an RN can be admitted onto the APN Registry upon successful completion of a nationally accredited education program for the preparation as an APN or a passing score on a certification exam of a nationally recognized accrediting agency. National board certification is not required to enter into practice.

Reimbursement

Medicaid reimbursement is available to PNs, FPNPs, CNMs, and CRNAs in Colorado. Third-party reimbursement is available to any RN; billed services qualify for reimbursement only if the type of service has a history of being reimbursable to other healthcare providers. No statutes require insurance companies to credential, empanel, and/or reimburse APNs; however, some insurance companies reimburse for NP services, especially related to psychiatric APNs with prescriptive privileges. No statutes or rules prohibit or constrain APNs in managed care.

Prescriptive Authority

Colorado APNs enjoy full prescriptive authority including Schedules II–V controlled substances. For prescriptive authority eligibility, the prescribing nurse must be listed on the APN registry and have a post-basic or graduate degree in a nursing specialty that includes at least 45 contact hours in health assessment, pharmacology, and pathophysiology. The APN must have satisfactorily completed education in the use of controlled substances and prescription drugs, have postgraduate experience as an APN in a relevant clinical setting of no less than 1,800 hours (in the immediately preceding 5-year period), and have a written collaborative agreement with a physician whose medical education and active practice correspond with that of the APN. The APN shall provide the BON with the collaborating physician’s name; that information will also be available to the BOP, BOM, and (except for DEA numbers) the public. APN law states that nothing shall be construed to limit the ability of the APN with prescriptive authority to make independent judgments, require supervision by a physician, or require the use of formularies. APNs with prescriptive authority are legally authorized to request, receive, and/or dispense pharmaceutical samples.

Connecticut

http://www.dph.state.ct.us/

Legal Authority

The Connecticut NPA defines APRNs as NPs, CNSS, and CRNAs, and authorizes APRNs to work in collaborative relationships with physicians. R&R specific to this law have not been written. Connecticut law defines collaboration as a mutually agreed on relationship between an APRN and a physician who is educated, trained, or has experience related to an APRN’s work. The collaboration between the physician and the APRN must include (1) reasonable and appropriate consultation and referral; (2) patient coverage in the absence of the APRN; (3) a method for reviewing patient outcomes; (4) a method of disclosing the collaborative relationship to the patient. Current law exempts CRNAs because their service is under the direction of a licensed physician. SOP for APRNs is defined in statute; however, CNM SOP is recognized under separate statute. The NPA authorizes RNs to continue into practice. Connecticut APNs with prescriptive authority are legally authorized to request, receive, and/or dispense pharmaceutical samples. NPs, psychiatric CNSs, and CNMs are reimbursed for services under state insurance statutes, which affect only private insurers. Reimbursable services must be within the individual’s scope of practice and must be services that are reimbursed if provided by any other healthcare provider. The law further states that insurers cannot require supervision or signature by any other healthcare provider as a condition of reimbursement.

Prescriptive Authority

APRNs working in a collaborative relationship with a physician may prescribe, dispense, and administer medications, including Schedules II–V controlled substances, that are expressly specified in the written collaborative agree-
If the agreement is with a licensed health care provider, or licensed health care delivery system.

The system will supply appropriate medical backup for purposes of consultation and referral. Requirements for physician supervision, chart review, or on-site physician visits do not exist. APN applicants must have a master’s degree or post-basic certificate in a clinical nursing specialty, be nationally certified, submit a copy of their collaborative agreement, and show evidence of BON-specified relevant courses including advanced health assessment, diagnosis and management of problems within the clinical specialty, advanced pathophysiology, and advanced pharmacology. If the APN has graduated from an approved program more than 2 years prior to application, the APN must document the equivalent of at least 30 hours continuing education in pharmacology and other areas.

**Legal Authority**

The Delaware BON and the Delaware BOM jointly regulate APNs and grant APN authority to practice. APNs are defined as NPs, CNSs, CNMs, and CRNAs. If the APN’s SOP does not include independent acts of diagnosis or prescribing, practice authority is governed solely by the BON. If the APN wishes to provide independent acts of diagnosis or prescribing, the APN must apply to the JPC (composed of APNs, physicians, a pharmacist, and one public member). The JPC is statutorily empowered, with Board of Medical Practice (BOMP) approval, to grant independent practice and/or prescriptive authority to nurses who qualify. APNs must practice in a collaborative relationship with physicians while performing these services. The collaborative agreement is a written document that outlines the process for consultation or referral complementary to the APN’s independent practice area. The collaborative agreement is defined as “a true collegial agreement between two parties where mutual goal-setting access, authority, and responsibility for actions belong to individual parties and there is a conviction to the belief that this collaborative agreement will continue to enhance patient outcomes, and a written document that outlines the process for consultation and referral between an APN and physician licensed in Delaware, dentist, podiatrist, or licensed health care delivery system.” If the agreement is with a licensed health care delivery system, the document must clarify that

**Prescriptive Authority**

JPC- and BOMP-approved APNs may prescribe, administer, and dispense legend drugs, including Schedules II-V controlled substances, parenteral medications, medical therapeutics, devices, and diagnostics. Authorized APNs are assigned a provider identifier number; APNs must register with the State Controlled Substance Agency and DEA, and use their number for prescribing controlled substances. Authorized APNs may request and issue professional samples of legend drugs, including Schedules II-V controlled substances and properly labeled over-the-counter drugs. The prescription order includes the APN’s name and prescriber identification number and the prescriber’s DEA number and signature when applicable.

**District of Columbia**

The Washington, D.C. Department of Health BON approves and regulates APNs. APNs are defined as ARNPs or CNPs, CNMs, CRNAs, and CNSSs. Current law, as described in the 1995 HORA amendments, authorizes APNs to practice without a physician collaborative agreement or protocols. CNP SOP is defined in statute, regulated by the BON, and without limitations. APNs apply for hospital privileges; however, admitting privileges were not reported on this survey. Graduation from a post-basic NP program or national certification in a specialty area are required to enter into practice.

**Reimbursement**

The 1995 HORA amendments authorized direct reimbursement of APNs for providing drug abuse, alcohol abuse, and mental illness care; healthcare plans or institutions are prohibited from discriminating against APNs with clinical privileges. Legislative authority that mandates APN reimbursement does not exist. Private, third-party payers reimburse for NP services. APNs are statutorily recognized as PCPs. NPs and CNMs receive Medicaid payment as PCPs.

**Prescriptive Authority**

The D.C. regulations provide for full prescriptive authority including Schedules II-V controlled substances. The collaborative agreement requirement has been abolished. The law and R&R authorize prescribing Schedules II-V controlled substances and allow dispensing. The D.C. Pharmacy Board began issuing DEA numbers in 1995.
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as PCPs. ARNPs are authorized to admit patients to the hospital and hold hospital privileges; however, this authority is dependent upon privileges granted by the institution. ARNP applicants must have a master's degree to qualify for initial certification and starting July 2006, are required to hold national board certification to enter practice.

Reimbursement
ARNPs receive Medicaid, Medicare, CHAMPS, and third-party reimbursement; however, Medicaid reimburses ARNPs at 100% of the physician rate only if the on-site physician countersigns the chart within 24 hours. Medicaid reimburses ARNs at 80% of the physician rate if the physician is not on site and does not countersign. Managed care companies are prohibited from discriminating against the reimbursement of ARNPs if based on licensure. Private insurers must reimburse CNMs services if the policy includes pregnancy care.

Prescriptive Authority
The BON/BOM joint committee allows prescriptive privileges for ARNPs, however, controlled substances are excluded. ARNPs prescribe under their protocol, which broadly lists the medical SOP and generic categories from which the ARNP can prescribe. ARNPs use their own prescription pad (containing name and license number); the pharmacist is required to put the prescriber's name on the drug label. ARNPs who dispense (distribute medication for reimbursement) must apply for dispensing privileges. ARNPs are authorized to request, receive, and/or dispense pharmaceutical samples.

Legal Authority
ARNPs are authorized to practice and regulated by the BON. APRNs are defined as NPs, CNMs, CRNAs, and CNSs in psychiatric mental health. An APRN is authorized to perform advanced nursing functions and certain medical acts that include, but are not limited to, ordering drugs, treatments, and diagnostic studies by protocol. A physician may delegate to an APRN, in accordance with a "nurse protocol," the authority to order controlled substances from a BOME formulary and the authority to order drugs, medical treatments, and diagnostic studies. A formulary has been developed in R&R. "Nurse protocol" is defined as a written document signed by the NP and physician in which the physician delegates authority to the nurse to perform certain medical acts and provides for immediate consultation with the delegating physician under OCGA 43-34-26. A master's degree or higher in nursing within the respective specialty and national certification is required for all APRNs at entry into practice.

Reimbursement
There are no statutes mandating third-party reimbursement for APRNs. FNP, PNPs, OB/GYN NPs, CNMs, and CRNAs are eligible for Medicaid reimbursement from the Department of Community Health. Reimbursement rates vary: NPs and CRNAs are reimbursed at 90% of a physician's payment and CNMs are reimbursed at 95% of a physician's payment. Some private insurers reimburse APNs but are not required by law to do so.

Prescriptive Authority
A process exists that permits RNs (including APRNs) to administer, order, or dispense drugs under delegated medical authority, either as prescribed by a physician or as authorized by protocol. BON regulations governing protocols used by RNs require that the RN document preparation and performance specific to each medical act. "Medication orders" may be called into a pharmacy. There are continuing legislative efforts to amend the current limitation and allow for such orders to be transmitted in writing.

Hawaii
http://www.state.hi.us/dcca/pvl/areas_nurse.html
2005 Legislative Accomplishments
A report was filed with the Hawaiian legislature related to the BOME statement that APRNs had authority to prescribe Schedules II-V controlled substances under supervision of a physician.

Legal Authority
The BON grants authority and regulates APRNs in Hawaii. APRNs are defined in the NPA as an NP, CNS, CNM, or CRNA. Hawaii does not legally require a collaborator or supervisory practice with a physician, with the exception of prescribing controlled substances. The APRN's SOP is defined in regulation (administrative rules). Hawaiian law does not specifically authorize APRNs to admit patients to the hospital or hold hospital privileges. The minimum degree required to enter practice in Hawaii is a master's in nursing, and national certification is required to enter into practice.

Reimbursement
Current law provides direct reimbursement to all APRNs; however, APRNs are not legally recognized as PCPs. According to Hawaiian authorities, several insurance companies credential APRNs for their provider panels. Some APRNs are listed on managed care panels and are directly reimbursed for services. The reimbursement rate ranges from 95% to 100%.

Prescriptive Authority
The BON regulates prescriptive authority and APRNs recently obtained legal authority to prescribe Schedules II-V controlled substances provided they have a supervisory relationship with a physician. APRN prescriptive authority for non-scheduled medications is not supervised; however, APRNs must document with the Department of Commerce and Consumer Affairs that they have a collegial working relationship with an MD working in the same "institution" and specialty area. APRNs prescribe from an exclusionary formulary. To prescribe from the formulary, APRNs must have a master's degree in nursing or nursing science, 30 hours of advanced pharmacology, 1,000 hours of clinical practice, and national certification. APRNs with prescriptive authority are legally authorized to request, receive, and dispense pharmaceutical samples. NP prescribers' prescriptions are labeled with both the NP and physician's name.

Idaho
http://www2.state.id.us/ibn/ibnhome.htm
Legal Authority
The BON regulates and grants authority to practice for Advanced Practice Professional Nurses (APPNs). APPNs are defined as NPs, CNMs, CNSs, and RNAs. APPN licensure requires RN licensure, completion of an approved APPN program, and national certification. NPs, CNMs, and CNSs must practice in collaboration with other health professionals. Revised NPA rules rely on the Decision Making Model to determine an APPN's scope of practice. The APPN can find out if a specific function can be legally performed by determining if the act: (1) is expressly forbidden in the NPA R&R; (2) was taught in the APPN curriculum and the APPN is clinically competent to perform it; (3) does not exceed employment policies; (4) is consistent with national specialty organization standards; and (5) is within the accepted standard of care for the APPN's geographic region and practice setting. APPNs are not statutorily recognized as PCPs; however, Idaho does have "any willing provider" language in its statute. APPNs are legally authorized to admit patients to hospitals and hold hospital privileges in Idaho. Some
facilities have granted APPNs privileges. State law requires a minimum of an associate’s degree as entry into practice; however, the NPA also requires national board certification to enter practice, which requires a master’s degree in nursing to enter into most specialties.

■ Reimbursement

Listing APPNs on managed care provider panels is neither specifically permitted nor prohibited and is considered by third-party payers on an individual basis. BC/BS credentials NPs as “preferred providers” within their program. NPs receive their own Medicaid provider number and may choose to file independently or with a group. Reimbursement rates are 85% of physician payment.

■ Prescriptive Authority

Prescriptive and dispensing authority is granted to APPNs who have completed 30 contact hours of pharmacology-specific formal instruction beyond basic RN education. Authorized APPNs may prescribe and dispense legend and Schedules II–V controlled substances appropriate to their defined scope of practice. Some dispensing restrictions apply to Schedule II substances. Authorized APPNs have their own DEA numbers and prescribe independently. APPNs are legally authorized to request, receive, and dispense pharmaceutical samples and NP prescribers’ prescriptions are labeled with the NP’s name only.

Illinois

http://www.ildpr.com

■ Legal Authority

The Illinois Department of Professional Regulation’s Advanced Practice Nursing Board grants authority and regulates practice of APNs. APNs are defined as CNPs, CNSs, CNMs, and CRNAs. CNPs, CNSs, and CNMs must have a written collaborative agreement with a physician that describes the working relationship between the APN and the physician and authorizes the categories of care, treatment, or procedures to be performed by the APN. Medical direction is adequate if the APN and physician jointly develop the guidelines and periodically review them. The physician’s presence is not required at the site where services are rendered; however, telecommunication methods for consultation must be established, and the physician is expected to visit the site at least once a month. CNP SOP is not defined in statute; however, Section 1305.30 Written Collaboration Agreements states, “The services to be provided by the advanced practice nurse shall be services that the collaborating physician generally provides to his or her patients in the normal course of his or her clinical medical practice.” All new applicants must have a graduate degree in their APN specialty or a graduate degree in nursing and a certificate from a graduate level program in one of the APN specialty areas. Additionally, APNs must hold national certification to enter into practice.

■ Reimbursement

The Illinois Department of Public Aid provides direct reimbursement at 100% of physician rates to certified PNs and FNs who enroll independently as Medicaid providers. PNs and FNs may alternately choose to bill under a physician and receive 100% reimbursement. Statutory prohibition for third-party reimbursement to APNs does not exist. APNs receive direct or indirect reimbursement from third-party payers in some cases.

■ Prescriptive Authority

Delegated prescriptive authority is granted to APNs by their written collaborative agreement for legend and Schedules III–V controlled substances. APNs use prescription pads containing their name and their collaborating physicians’ name; only the APN’s signature is required. APNs are not required to have their collaborating physician sign (IDPR Illinois Department of Professional Regulation) forms for prescriptive authority as long as they are not controlled substance prescriptions; in this case, APNs need only note that the APN has prescriptive authority in the collaborative agreement. In order for an APN to prescribe controlled substances, she or he has to first obtain a CSL (Illinois Controlled Substance License) before applying for a DEA registration; the physician must sign a “Notice of Delegation of Rx Authority for Controlled Substances” form. The collaborating physician shall review medication orders periodically. An APN may sign for and accept drug samples if it is stipulated in the written collaborative agreement.

Indiana

http://www.in.gov/hpb/boards/sbn/appinst.html

2005 Legislative Accomplishments

The passage of HB 1073 granted immunity from civil or criminal liability to a licensed physician, optometrist, or APN who makes a good faith report to the bureau concerning a patient’s fitness to operate a motor vehicle not more than 30 days after having examined a patient.

■ Legal Authority

The Indiana State Bon grants authority to and regulates APNs. The NPA defines APNs as NPs, CNMs, or CNSs. The Bon does not issue separate licenses to NPs or CNSs. CNMs must apply for “limited licensure” to practice. CRNAs are licensed and regulated by the Bon under a separate statute from the APNs. APNs without prescriptive authority may function independently in their advanced practice; however, a Written Collaborative Practice Agreement (WCPA) is necessary if the APN seeks prescriptive authority. APN SOP is defined in regulation. NPs are licensed following completion of a graduate program that is accredited according to Bon regulation or completion of a certificate NP program and national certification by a national certifying body for NPs. If the NP holds a baccalaureate degree, national certification is required to obtain prescriptive authority. NPs with a graduate degree do not need to be nationally certified for prescriptive authority to be granted.

■ Reimbursement

Indiana is considered an “any willing provider” state, backed by current law. APNs may receive third-party reimbursement as determined by payers. NPs receive Medicaid reimbursement at 85% of a physician’s payment. Medicaid for children, however, does not allow for NP reimbursement under current managed care arrangements.

■ Prescriptive Authority

The Bon has legal authority to establish rules, and, with the approval of the BOM, to permit prescriptive authority for APNs. The Bon may issue authorization to prescribe legend drugs and controlled substances if the qualified APN submits proof of successful completion of a graduate-level pharmacology course, consisting of at least 2 accredited semester hours. Additionally, the APN must submit proof of collaboration with a “licensed practitioner” (licensed physician, dentist, podiatrist, or osteopath) in the form of a WCPA. WCPAs must be approved by the Bon and include (1) the manner in which the APN and licensed physician will cooperate, coordinate, and consult with each other in the provision of healthcare, and (2) the specifics of the licensed physician’s reasonable and timely review of the APN’s Rx practices, including the provision for a minimum weekly review of 5% random chart sampling. The Bon issues a prescriptive authority identification number; the authority limits APN prescribing to within the APN’s and collaborating physician’s SOP. APNs requesting authority to prescribe controlled substances must apply for and obtain Indiana State Controlled Substances Registration before obtaining a federal DEA number. Prescriptions are labeled with the APN’s name only. APNs are not permitted to prescribe Schedules III and IV controlled substances for the purpose of weight reduction or to control obesity, and must follow specific guidelines before prescribing a stimulant for attention deficit hyperactivity disorder. CRNAs are not required to obtain Rx authority to administer anesthesia. APNs are not legally authorized to request, receive, and/or dispense pharmaceutical samples.

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Iowa

http://www.state.ia.us/nursing/

2005 Legislative Accomplishments

ARNP Compact House File 784 authorized the Iowa BON to participate in national discussions about a compact for advanced practice nursing. Iowa is the second state to pass authorizing legislation.

Legal Authority

The Iowa BON grants ARNPs authority to practice and regulates their practice through administrative rules. ARNP's are defined as NPs, CRNAs, CNMs, and CNSs, and are certified separately from their RN license. ARNP's are authorized to practice independently within their recognized nursing specialties and collaborative practice agreements are not required; however, an ARNP may perform selected medicolegally delegated functions only when a collaborative practice agreement exists. Scope of practice is not defined in statute or regulation. ARNPs are statutorily recognized as “primary care providers”; however, state law does not contain “any willing provider language.” ARNPs may hold hospital clinical privileges. A master’s degree in nursing is required for advanced practice in a nursing clinical specialty and ARNPs must hold national certification to practice.

Reimbursement

Payment of necessary medical or surgical care and treatment is provided to an ARNP if the policy or contract would pay for the care and treatment when provided by a physician or DO. Managed care organizations are not mandated to offer ARNP coverage unless there is a contract or other agreement to provide the service. Under 2003 legislation, all ARNP's are approved as providers of healthcare services pursuant to managed care or prepaid service contracts under the medical assistance program.

Prescriptive Authority

Authorized ARNP's are granted independent Rx authority within their nursing specialty, which includes Schedules II-V controlled substances. ARNP's may prescribe, deliver, distribute, or dispense noncontrolled and controlled drugs, devices, and medical gasses, including pharmaceutical samples. Registration with the federal DEA and the Iowa BOP extends this authority to controlled substances. ARNP's write prescriptions using their own prescription pads.

Kentucky

http://kbn.ky.gov

2005 Legislative Accomplishments

The passage of HB 72 revises the biannual licensure renewal cycle for ARNP's to annual renewal.

Legal Authority

The Kentucky BON grants ARNP's authority to practice and regulates their practice. ARNP's are statutorily defined as NPs, CNSs, CNMs, and CRNAs. ARNP's practice in collaboration with a physician in Kentucky for prescriptive purposes only. ARNP's may practice autonomously within their relative scopes of practice; however, they must practice in accordance with the SOP of the national certifying organization as adopted by the BON in regulation. ARNP's shall seek consultation or referral in situations outside their scope of practice. ARNP's are recognized as "primary care providers" in regulation, and are legally authorized to admit patients to a hospital and hold hospital privileges; however, hospital regulations permit medical staff to set conditions. A master's degree in nursing and national board certification is required to enter practice in Kentucky.

Reimbursement

Insurance companies are legally required to reimburse all ARNP's for covered services in health plans. Medicaid has expanded payment to include all covered services at 80% of physician payments (except for practitioners performing periodic screening and diagnosis and treatment; they receive 100%). NAs receive 85% of physician payments. Some insurance companies are paying 85% of physician payments to ARNP's.

Prescriptive Authority

ARNP’s, with the exception of CRNAs, are legally authorized to prescribe medications, including Schedules II-V controlled substances pursuant to protocols jointly adopted by the ARNP and the “responsible physician.” Each written protocol must (1) specify the drug class the ARNP is permitted to prescribe for each classification of disease or injury; (2) be maintained in a notebook or book of published protocols; and (3) contain the ARNP’s and physician’s annual signature. The prescription order must be signed by the ARNP and include the name of the physician and ARNP. Prescription labels include both the ARNP and physician’s name. ARNP's are authorized to request, receive, and dispense pharmaceutical samples if the drug is within their protocol.

Louisiana

http://www.lsbn.state.la.us

2005 Legislative Accomplishments

The passage of HB 158, Act 200 authorized NPs in Louisiana to sign medical excuses for the educational system.
Legal Authority
APRNs are licensed by the BON and are defined as NPs, CNMs, CRNAs or RNAs, and CNSs. APRNs perform certain acts of medical diagnosis in accordance with a “collaborative practice agreement,” a formal written statement addressing the parameters of the collaborative practice which are mutually agreed upon by the APRN and one or more physicians or dentists including consultation or referral availability, clinical practice guidelines, and patient coverage. APRNs’ SOP is limited to their BON-recognized category and area of specialization. The APRN SOP includes “certain acts of medical diagnosis or medical prescriptions of a therapeutic or corrective nature, prescribing assessment studies, legend and certain controlled drugs, therapeutic regimens, medical devices and appliances, receiving and distributing a therapeutic regimen of prepackaged drugs prepared and labeled by a pharmacist, and free samples supplied by a drug manufacturer.” The BON has approved numerous CPT codes for APRNs and continues to do so. APRNs must be licensed as an RN, possess a master’s degree or higher, and be certified by a national certifying body recognized by the board or meet “commensurate requirements” if certification is not available.

Reimbursement
General mandatory reimbursement for APRNs does not exist. Medicaid managed care is required to reimburse APRNs at a rate equal to that of physicians performing the same service. As of October 2004, Medicaid changed their position on NPs as primary care case managers/providers and will give assignment of NPs as the PCP or Medical Home under certain circumstances. APRNs are reimbursed at 80% of physician fees per Medicaid; all billing must be under the APRN license, essentially eliminating “incident to” billing.

Prescriptive Authority
APRNs have prescriptive authority in Louisiana, including Schedules II-V controlled substances. The BON has sole authority to develop, adapt, and revise R&R governing SOP, including Rx authority, the receipt and distribution of sample and prepackaged drugs, and prescribing of legend and certain controlled drugs. The R&R have been promulgated and the BON is waiting the specified time period put forth in the Administrative Procedure Act. Under the previous rules, the applicant for Rx authority must provide evidence of a collaborative practice agreement with a licensed physician or physician group and include a plan of accountability to include clinical practice guidelines, availability of a collaborating physician, and patient care coverage plans with documented review of the guidelines with the on-call physician. The Rx R&R limit one physician to no more than two APRNs and require, with some site exceptions, that the physician visit the APRN practice site at least weekly. An APRN who is granted limited Rx authority may request approval to prescribe and distribute controlled substances as authorized by the APRN’s collaborating physician if the patient population served by the collaborative practice has an identified need. Prescribing distributed controlled substances (Schedules III-V) must be consistent with the practice specialty of the collaborating physician and the APRN’s licensed category and area of specialization. The BON approved certain Schedule II drugs to treat attention deficit hyperactivity disorder. APRNs with authority to prescribe or distribute controlled substances may not prescribe controlled substances to treat chronic or intractable pain or obesity, or themselves or family.

Maine
http://www.state.me.us/boardofnursing/
http://www.mnpa.us

2005 Legislative Accomplishments
The passage of LD 1568 (HP 1106) allowed NPs to sign death certificates. This emergency measure went into effect on the date of its passage, June 9, 2005. Also, the passage of LD 809 (HP 574) allowed NPs to facilitate testimony in workers’ compensation proceedings.

Legal Authority
The Maine BON authorizes and regulates APRN practice. APRNs approved by the BON are defined as CNPs, CNMs, CNSs, and CRNAs. A CNP who qualifies as an APRN must practice for at least 24 months under the supervision of a licensed physician or must be employed by a clinic or hospital that has a medical director who is a licensed physician. The CNP must submit written evidence to the BON upon completion of the required clinical experience. After this 24-month period, the CNP can practice independently. CNSs practice independently. CRNAs are responsible and accountable to a physician or dentist. The APRN scope of practice, as defined in regulation, includes standards of the national certifying body and “consultation with or referral to medical and other healthcare providers when required by client healthcare needs.” CNPs and certified psychiatric CNSs may sign documents for emergency involuntary commitment through emergency departments. APRNs are statutorily defined as “primary care providers,” and may be credentialed as allied staff for hospital privileges. Admitting privileges are not granted in this authority. Workers’ compensation forms recognize CNPs and allow issuance of license plates and cards for the physically disabled. Previous law stated that APRNs must have graduated from an approved NP program; however, as of January 1, 2006, a master’s in nursing is required to enter into practice. National certification is required to practice in the state of Maine.

Reimbursement
The 1999 Act to Increase Access to Primary Health Care Services (HP 617) requires reimbursement under an indemnity or managed care plan for patient visits to an NP or CNM when referred from a PCP; requires insurers to assign separate provider identification numbers to CNPs and CNMs; and allows managed care enrollees to designate CNPs as their PCP. However, managed care organizations are not required to credential any physician or CNP if their “access standards” have been met. Reimbursement under indemnity plans is mandated for master’s-prepared, certified psychiatric/mental health CNSs; no other third-party reimbursement for APRNs is required by law. Some insurance carriers, however, reimburse independent CNPs. Medicaid reimburses services provided by CNPs, CPNPs, and CNMs in full on a fee-for-service basis.

Prescriptive Authority
A CNP or CNM who qualifies as an APRN may prescribe and dispense drugs or devices in accordance with rules adopted by the BON; approved CNPs and CNMs receive their own DEA numbers. BON rules require CNPs and CNMs to have a pharmacology course and prescribe from FDA-approved drugs related to the nurse’s specialty. CNPs in independent practice and CNMs may prescribe Schedule II controlled substances and drugs off-label, according to common and established standards of practice. Dependency on other professionals for APRN prescriptive authority does not exist, except in the case of CNPs working pursuant to medical delegation by a physician (an employment practice required by a number of Maine hospitals). CNPs working pursuant to medical delegation may now prescribe Schedule II controlled substance medications after written request to the BOM and their approval. APRNs may receive and distribute drug samples included in the formulary for Rx writing.

Maryland
http://www.mfibon.org

2005 Legislative Accomplishments
The passage of HB 399 allows the board to issue temporary practice letters for NPs and nurse midwives. The APN can now work while the collaborative agreements are being reviewed by the BOM and BOM.

Legal Authority
The Maryland BON and BOM jointly regulate APRN practice. APNs are defined as NPs, CRNAs, CRNMs, and APRNs or psychiatric mental health nurses. APNs are legally required to have a written agreement with a collaborat-
Legal Authority

The Massachusetts BON grants APNs authority to practice and regulates their practice. APNs are defined as NPs, NAs, psychiatric clinical nurse specialists (PCNSs) and CNMs. All APNs practice in accordance with written guidelines developed in collaboration with the nurse and supervising physician. In all cases, the written guidelines “designate a physician who shall provide medical direction as is customarily accepted in the specialty area.” If practicing in an institution, the nursing and medical administrative staff must approve the guidelines. If there is no nursing and medical administrative staff, the guidelines must be approved by the BON. Advanced practice R&R governing the ordering of tests, therapeutics, and prescribing are promulgated by the BON in conjunction with the BON. All other areas of SOP are exclusively under the BON. SOP is defined both in statute and regulation. Massachusetts does not recognize APNs as primary care providers and does not have “any willing provider” language in law. Credentialing for hospital privileges varies according to hospital policies. Although Massachusetts does not have a minimum degree requirement for entry into practice, national certification is required, which does require a minimum of a master’s degree to obtain.

Reimbursement

FNPs, PNPs, and adult nurse practitioners are reimbursed at 100% of physician payment rate for Medicaid unless the NP is employed by the hospital in a hospital-based practice. Massachusetts state law mandates reimbursement to NPs, PCs, CNMs, and NAs in accordance with Chapter 302 of the Acts and Resolves of 1994. These include indemnity plans, non-profit hospital corporations, medical service corporations, and health maintenance organizations. BC/BS, Fallon, and Neighborhood Health Plan credential NPs in private practice settings to receive individual provider numbers. An HMO protection statute allows “other providers” to be listed on panels; however, the law does not specifically address APNs or require them to be listed as providers.

Prescriptive Authority

Massachusetts state law provides for prescriptive authority for NPs, CNMs, and PCNSs, including Schedule II controlled substances. Authorized APNs must apply to the Massachusetts Department of Public Health for state registration, then apply for a federal DEA number. Authorized APNs have (1) prescribing guidelines mutually developed and agreed on by the nurse and supervising physician; guidelines do not need to be submitted to the BON unless requested. Guidelines pertaining to prescriptive practice shall include a defined mechanism to monitor prescribing practices, including review with the supervising physician at least every 3 months—with the exception of initial prescription of Schedule II drugs, which requires review within 96 hours. Authorized APNs are allowed to request, receive, and dispense pharmaceutical samples. The prescription label and pad include the name of the supervising physician and the APN; however, the authorized APN signs the prescription.

Michigan

http://www.michigan.gov/cis

2005 Legislative Accomplishments

The following legislation was passed this year to include NP language: Bus driver physical exams; civil service employee physical exams; civil service police and fire employee exams; handicap parking permits; driver’s training instructional permits; pre-participation boxing exams; and license fee to conduct boxing exams.

Legal Authority

The Michigan BON advanced practice authority as a specialty certification. Nurse specialists are defined as CNMs, CRNAs, and NPs. Nurse specialists are not required to have physician collaboration or supervision, with the exception of prescriptive authority. SOP is defined in statute, and under some health maintenance organizations and systems NPs are recognized as “primary care providers.” Michigan does not have “any willing provider” language in statute. Michigan statute does not specifically authorize nurse specialists to admit patients or hold hospital privileges; however, according to the state nursing association, this depends on the institution, but hospitals generally grant these privileges. Nurse specialists are required to have a master’s degree in nursing and national board certification to enter into practice.

Reimbursement

Medicaid directly reimburses all certified NPs at 100% of the reimbursement rate. BC/BS directly reimburses all NPs, CNMs, and CRNAs, however, the statute does not legally require insurance companies to credential, empanel, or recognize nurse specialists.

Prescriptive Authority

Under the Michigan Public Health Code, a prescriber is defined as “a licensed health professional acting under the delegation and supervision of and using, recording, or otherwise indicating the name of the delegating physician.” NPs, CRNAs, and CNMs may prescribe...
noncontrolled substances as a delegated act of a physician. There is no requirement for a physician countersignature. Under BOM administrative rules, a physician may delegate prescriptive authority for Schedules III-V controlled substances to NPs and CNMs if “the delegating physician establishes a written authorization,” containing names and license numbers of the physician and NP or CNM and the limitations or exceptions to the delegation. Written authorizations must be reviewed annually. The DEA requires NPs and CNMs to obtain DEA numbers for those prescribing controlled substances. Schedule II controlled substances may also be delegated if the physician and NP or CNM are practicing within a defined health facility (freestanding surgical outpatient facility, hospital, or hospice) and if, on discharge, the prescription does not exceed a 7-day period. A supervising physician may delegate in writing the ordering, receipt, and dispensing of complimentary starter dose drugs other than controlled substances. Prescription labels are labeled with the name of the physician.

Minnesota
http://www.nursingboard.state.mn.us

Legal Authority
The Minnesota BON grants APRNs authority to practice and regulates their practice. APRNs are defined as a registered nurse certified by a national nursing certification organization acceptable by the BON to practice as a CNP, CNS, CRNP, or CRNA. APNs in Minnesota practice in a collaborative relationship with physicians. Collaborative management is defined as a mutually agreed on plan between an APRN and physician(s) that designates the scope of collaboration necessary to manage the care of patients in which the APRN and physician(s) have experience in providing care to patients with the same or similar medical problems. CNPs, CNSs, and CRNAs must practice within the context of collaborative management. CNMs may practice within a system that provides for consultation, collaborative management, and referral. SOP for CNPs is defined in statute, and CNPs are legally recognized as PCPs. Minnesota state law does not contain “any willing provider” language, however. APRNs are legally authorized to admit patients to a hospital and hold hospital privileges as defined within their scope of practice. Minnesota does not identify a minimum degree requirement for entry into practice, however, the state does require national board certification to enter practice.

Reimbursement
APRNs may enroll with Medicaid as a provider and bill for services. FNPs, PNP, GNP, WHNP, and ANPs are reimbursed by Medicaid at 90% of the physician rate. CNPs, CNMs, CRNAs, and CNSs in psychiatric health have legal authority for private insurance reimbursement. Minnesota law prohibits HMOs and private insurers from requiring a physician cosignature when an APRN orders a laboratory test, X-ray, or diagnostic test.

Prescriptive Authority
APRNs who meet statutory requirements may prescribe, receive, dispense, and administer drugs including controlled substances Schedules II-V within the scope of their written agreement with a physician and within the practice specialty. CNPs, CRNAs, and CNSSs must have a written agreement with a physician that defines the delegated responsibilities related to prescribing drugs and devices. CNMs have independent Rx authority. The BON does not grant prescriptive authority; however, they do have the authority to discipline the APRN if the prescribing practices are unsafe, unethical, or illegal. An authorized APRN who chooses to prescribe controlled substances must apply to the DEA and verify compliance with Minnesota prescribing laws with the BON. APRNs have statutory authority to receive and dispense sample drugs within their authorized scope of practice. Schedules II-V may be prescribed pursuant to additional BON-R&R and the NP must have a DEA number, completed a BON-approved educational program, and submit a “controlled substance prescriptive authority protocol” to the BON. CNMs and CRNAs may order controlled substances within a licensed healthcare facility using BON-approved protocol or practice guidelines.

Mississippi
http://www.msbn.state.ms.us

Legal Authority
The Mississippi BON grants APNs authority to practice and regulates their practice. APNs are defined as NPs, CRNAs, and CNMs. The R&R are jointly promulgated by the BON and BOM, and implemented by the BON. APNs practice in a collaborative relationship with physicians in Mississippi. The collaborating physician’s practice must be compatible with the NP. NPs must practice according to a BON-approved protocol agreed on by the NP and physician. NP applicants must submit official evidence of graduation from a graduate program with a collaborative Practice (CP) rule. Three focus areas in the CP rule include: (1) geographic areas to be covered, (2) methods of treatment that may be covered by CP arrangements, and (3) requirements for review of services provided pursuant to a CP arrangement. A written CP arrangement with a physician is not needed when the APN is performing nursing acts consistent with the APNs skill, training, education, and competence. A CP arrangement may be indicated to perform physician-delegated medical acts within the mutual SOP of the physician and APRN and consistent with the APRNs skill, training, education, and competence. CRNAs practice under the direction of the surgeon or anesthesiologist. Individuals are recognized by their specific clinical nursing specialty area as a CNS, NP, NM, or CRNA, which delineates their title and SOP as APNs in R&R. When practicing outside their recognized clinical nursing specialty, individuals must practice and title as RNs only. Missouri law does not recognize APNs as “primary care providers” and does not contain “any willing provider” language. Additionally, APNs are not legally authorized to admit pa-
tients or hold hospital privileges. NPs are re-
quired to hold a master’s degree in nursing and
national certification to enter into practice in
Missouri.

■ Reimbursement
Current law states, “Any health insurer, non-
profit health service plan, or health mainte-
nance organization shall reimburse a claim for
services provided by an APRN, if such services
are within the scope of practice of such a
urse.” Medicaid reimbursement is made to
APRNs enrolled as Missouri Medicaid fee-for-
service providers and Medicaid-enrolled
APRNs associated with a federally qualified
healthcare and/or rural healthcare facility.
Medicaid reimbursement is limited to services
furnished by enrolled APRNs who are within the
SOP allowed by federal and state laws and
inpatient or outpatient hospital services or
clinic services furnished to the extent permit-
ted by the facility. Reimbursement for services
provided by APRNs is at the same rate and
subject to the same limitations as physicians.

■ Prescriptive Authority
Prescriptive authority for APRNs is limited to
prescription drugs and devices without con-
trolled substances as delegated by a physi-
cian pursuant to a written CP arrangement.
Delivery of such APRN healthcare services
shall be within the APRN’s advanced clinical
nursing specialty area and a mutual SOP with the
physician, and be consistent with the indi-
vidual’s skill, training, education, and compe-
tence. APRNs may receive/dispense samples
within their Rx authority. In certain instances,
state BNDD number is required. Prescrip-
tions written by an NP are labeled with both
the collaborating physician’s and NP’s name.

Montana
http://www.nurse.mt.gov

2005 Legislative Accomplishments
The passage of HB 203.1 requires one mem-
ber of the Board of Registered Nursing to be
an APRN.

■ Legal Authority
The Montana BON grants APRNs authority to
practice and regulates their practice. APRNs
are defined as NPs, CNSSs, CNMs, and CRNAs.
APRNs practice independently after comple-
tion of specific curriculum requirements and a
national certifying examination by a BON-rec-
ognized national certifying body. According to
the Montana BON, all APRNs enrolled in direct
patient care must have an approved quality as-
surance program in place. NP SOP is defined
in rule ARM 8.32.301, and they are statutorily
recognized as “primary care providers.” Mon-
tana state law, however, does not contain “any
willing provider” language. APRNs are legally
authorized to admit patients and hold hospital
privileges, however, this varies according to the
rules and bylaws of each hospital. APRNs must
have a master’s degree in nursing and hold na-
tional certification to enter into practice. All
APRNs must achieve mandatory continuing ed-
ocation hours for renewal every 2 years.

■ Reimbursement
Medicaid reimburses APRNs at 85% of physi-
cian payment. Montana law requires indemnity
plans to reimburse APRNs for all areas and ser-
VICES for which a policy would reimburse a
physician; however, HMOs are not included in
the indemnity insurers law—mandatory cover-
age for APRNs does not apply to HMOs. APRNs
receive 85% of the physician payment from
BC/BS. Medicare reimbursement consistent
with 1990 federal guidelines is in effect. APRNs
are included as providers for workers’ com-
pensation.

■ Prescriptive Authority
APRNs who desire Rx authority must apply for
recognition by the BON through the recom-
modation of the Prescriptive Authority Com-
mittee, consisting of BON members. APRNs
with prescriptive authority are authorized to
prescribe all medications, including Schedules
II-V controlled substances, using their own
DEA number, and are permitted to receive and
dispense drug samples. Authority to prescribe
is not dependent on any other health profes-
sional. Prescribing APRNs must have a quality
assurance program in place, with a defined
process of referral. The quality assurance
method must be BON-approved before is-
suance of prescriptive authority and include
15 charts, or 5% of all APRN charts, reviewed
quarterly by an APRN or physician in the same
specialty. Additional continuing education for
prescriptive authority (additional to CE require-
ment for practice authority) is required for re-
novation every 2 years.

Nebraska
http://www.hhs.state.ne.us/index.htm

2005 Legislative Accomplishments
LB 256 passed the Nebraska State Legislature
and was signed into law, defining APRNs and
creating one separate APRN Board that will reg-
ulate their practice. This bill also allows for li-
censure of CNSs. LB 256 goes into effect in 2007.
Bill language can be viewed at http://www. uni-
cam.state.ne.us.

■ Legal Authority
The Nebraska Advanced Practice Registered
Nursing Board grants APRNs authority to prac-
tice and regulates their practice. APRNs are
defined as NPs, CRNAs, CNMs, and CNSSs.
APRNs and physicians practice collaboratively
and have joint responsibility for patient care,
based on the SOP of each practitioner. The col-
laborative agreement is contained within the
integrated practice agreement (IPA). An IPA
specifies, “The collaborating physician shall be
responsible for supervision through ready avail-
ability for consultation and direction of the ac-
tivities of the APRN.” If, after diligent effort, an
APRN is unable to obtain an IPA with a physi-
cian, the APRN Board may waive the require-
ment for an IPA if the APRN has demonstrated
proper course work, holds a master’s degree or
higher in nursing, has completed 2,000 hours
under the supervision of a physician, and will
practice in a geographic area where there is a
shortage of healthcare services. APRN SOP is
defined in statute and includes illness preven-
tion, diagnosis, treatment, and management of
common health problems and chronic condi-
tions. “Primary care provider” status and “any
willing provider” language was not reported in
the survey. APRNs without a master’s or doc-
toral degree, and/or at least 2,000 hours of physi-
cian-supervised practice must also have jointly
approved protocols. APRNs licensed after 1996
must have a master’s or doctoral degree to
practice, except for women’s health and neonatal
practice. Nebraska requires national board
certification to enter practice.

■ Reimbursement
State legislation mandating third-party reim-
bursment for APRNs does not exist; conse-
quently, some APRNs have been refused recog-
nition as a provider. Medicaid reimburses
APRNs at 100% of physician payment.

■ Prescriptive Authority
Nebraska APRNs are authorized full prescrip-
tive authority including Schedules II-V medica-
tions, as defined in their statute. Schedule II
controlled substances are limited to 72 hours
and for pain control only. APRNs may request,
receive, and dispense pharmaceutical samples
if the samples are drugs within their prescrib-
ing authority. Labeling of prescription labels
with the NP name was not reported in the sur-
vey. CRNAs prescribe within their specialty
practice; authority is implied in the statute. Qual-
ified CRNAs and APRNs receive DEA numbers.
CNMs may not obtain DEA numbers, as their
authority to prescribe is dependent, based on
the practice agreement.

Nevada
http://www.nursingboard.state.nv.us

■ Legal Authority
The Nevada BON grants APNs authority to prac-
tice and regulates their practice. APNs are de-
efined as NPs, CNSSs, and nurse psychotherapists
with a master’s degree. APNs in Nevada prac-
tice in collaboration with a physician. The APN
must keep written protocols at every job site, to-
gether with a collaborative agreement signed by
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ARNPs authority to practice and regulates their practice. APNs are defined as NPs and CNs. APNs practice in collaboration with physicians and are required to have a Joint Protocol with the collaborating physician for prescribing purposes only. SDP for APNs is defined in statute. APNs are recognized as “primary care providers”; however, New Mexico does not have “any willing provider” language in statute. APNs are legally authorized to admit patients and hold hospital privileges; however, this is not defined by statute or regulation. Privileges are determined through the credentialing/privileging process of individual healthcare institutions. APN applicants must be master’s prepared in nursing and national board certification is required to enter into practice in New Mexico.

Prescriptive Authority
APNs and CRNAs receive third-party reimbursement. Hospital privileges are available to qualified APNs. Reimbursement from private insurance is at the same rate as the physician payment. Medicaid reimbursement is available to all APNs at 85% of physician payment.

Prescriptive Authority
BON-authorized APNs may prescribe controlled substances, including Schedules II-V medications, poisons, and dangerous drugs and devices pursuant to a protocol approved by a collaborating physician. A protocol must not include and an APN shall not engage in any diagnosis, treatment, or other conduct which the APN is not qualified to perform.” APNs may prescribe controlled substances, poisons, and dangerous drugs and devices if authorized by the BON and if a certificate of registration is applied for and obtained from the BOP. APNs register for their own DEA numbers. APNs may pass a BON examination for dispensing and, after passing the examination with BON approval, apply to the BOP for a dispensing certificate. Samples are not considered “dispensing”; APNs with prescriptive authority may receive and distribute samples without having dispensing authority.

New Hampshire
http://www.state.nh.us/nursing

2005 Legislative Accomplishments
The passage of SB 170 included a comprehensive revision of the Nurse Practice Act. This bill added an “SOP” section for each level of licensee, including ARNPs. Additionally, the Joint Health Council adopted new definitions for the terms “consultation” and “collaboration” within the official ARNP exclusionary drug formulary. Specific language to the NPA can be found at the Web site above.

Legal Authority
The New Hampshire Board of Nursing grants ARNP authority to practice and regulates practice. ARNPs are defined as NPs, CNs, CRNs, and psychiatric mental health clinical specialists. ARNPs do not require physician collaboration or supervision. ARNP SDP is now defined in statute. ARNPS are statutorily recognized as “primary care providers” in New Hampshire; however, New Jersey does not have “any willing provider” language in statute. ARNPs are recognized as “primary care providers”; however, New Jersey does not have “any willing provider” language in statute. ARNPs are legally authorized to admit patients and hold hospital privileges; however, this is not defined by statute or regulation. Privileges are determined through the credentialing/privileging process of individual healthcare institutions. ARNP applicants must be master’s prepared in nursing and national board certification is required to enter into practice in New Jersey.

Reimbursement
All major insurance companies, hospital service corporations, medical service corporations, and nonprofit health service corporations must reimburse ARNPs when the insurance policy provides for any service that may be legally performed by the ARNP and such service is rendered. ARNPs are recognized as PCPs by several HMOs in the state. Medicaid reimburses ARNPs at 100% of physician payment.

Prescriptive Authority
BON-licensed ARNPs have plenary authority to prescribe controlled and noncontrolled drugs from the official exclusionary formulary determined by the Joint Health Council, whose membership consists of three ARNPs appointed from the BON, three physicians appointed by the BOM who work with ARNPs, and three pharmacists appointed by the BOP. ARNPs are assigned a DEA number on request and after licensure as an ARNP. ARNPs are authorized to request, receive, and dispense pharmaceutical samples. Prescription labels are labeled with the ARNP name.

New Jersey
http://www.state.nj.us/lps/ca/medical.htm
http://www.njsnja.org

2005 Legislative Accomplishments
P.L. 2004, c. 168 was signed by the acting governor, which added APNs to the list of providers who can perform examinations, sign working papers, and certify temporary disability. Also, with the passage of the APN Controlled Substance Prescribing Statute in 2004, the New Jersey BON has issued a letter to all APNs on how to implement the provisions of the statute prior to the release of the regulations concerning this recent statutory amendment. If the APN has completed a 6-hour controlled substance prescribing course and amends the joint protocol to include the initiation of controlled substance medications, the APN may initiate controlled substance prescriptions for patients.

Legal Authority
The New Jersey BON grants APN authority to practice and regulates their practice. APNs are defined as NPs and CNs. APNs practice in collaboration with physicians and are required to have a Joint Protocol with the collaborating physician for prescribing purposes only. SDP for APNs is defined in statute. APNs are recognized as “primary care providers”; however, New Jersey does not have “any willing provider” language contained within the statute. APNs are legally authorized to hold admitting and hospital privileges. A mas-
ter’s degree in nursing or higher and national board certification is required to enter into practice as a CNP. The BON also regulates CRNAs and CNSs. CRNAs seeking initial licensure must be at the master’s level or higher. CRNAs work in collaboration with a physician and have Rx authority including Schedules II-V controlled substances. CNSs must be master’s prepared and certified by a national certifying nursing organization. CNSs “make independent decisions”, have “prescriptive authority,” including Schedules II-V controlled substances; and can distribute prepackaged drugs. CNMs are regulated by the Department of Health. CNPs can serve as “acute, chronic, long-term, and end-of-life health care providers.”

Reimbursement
Statutory authority for third-party reimbursement for NPs and CNMs has been in effect since 1987; however, reimbursement is not legally mandated for CNP services, thus CNPs continue to meet resistance in being listed as PCPs with some companies. FNPs and PNP’s receive Medicaid reimbursement at 85% of physician payment. All three of the managed care groups contracted to provide Medicaid coverage have contracts with NPs.

Prescriptive Authority
CNPs have full, independent prescriptive authority, including Schedules II-V controlled substances. BON prerequisites to prescribe controlled substances include experience with Rx writing, a state-controlled substance license, and a DEA number. Each CNP must maintain a formulary and submit a copy to the BON. CNSs must have graduate-level pharmacology, pathophysiology, a physical assessment course, and prescribe in collaboration with a physician, CNP, or CNS with Rx authority during a 400-hour preceptorship before they can prescribe independently. CNMs have Rx authority; the Department of Health has rule-making authority. CRNAs who meet prescriptive authority requirements may collaborate independently and prescribe and administer therapeutic measures, including dangerous drugs and controlled substances within emergency procedures, peripartum care, or perinatal care environments. CNPs and CNSs with prescriptive authority may distribute dangerous drugs and Schedules II-V controlled substances that have been prepared, packaged, or prepackaged by a pharmacist or pharmaceutical company. Prescription labels are labeled with the NP name, where appropriate.

New York

http://www.op.nysed.gov/nurse.htm

Legal Authority
The New York State Education Department grants NPs authority to practice and regulates their practice. APNs are defined as NPs. NPs are licensed as registered nurses (RNs) by the Board of Nursing and certified by the State Education Department as NPs. NPs are legally required to practice in collaboration with physicians in accordance with a written practice agreement and written practice protocols. NP SOP is defined in statute. NPs are considered independent practitioners who are authorized to diagnose, treat, and prescribe in accordance with collaborative practice. The written agreement must include a provision for dispute resolution between the NP and the physician and provisions for a review by the collaborating physician of a patient record sample at least every 3 months. NPs are statutorily recognized as “primary care providers”; however, New York state law does not contain “any willing provider” language. NPs are legally authorized to hold admitting and hospital privileges. A master’s degree in nursing is required to enter into practice; however, national board certification is not required.

Reimbursement
NPs of all specialties may register as Medicaid providers and NPs are specifically mentioned as qualified “primary care gatekeepers.” A law regulates the practice of HMOs: Provisions are provider-neutral and apply equally to physician and non-physician providers. Although there is no guarantee that APNs will have a role in managed care delivery, their rights are assured. The law also prohibits “gagging” health care providers, establishes due process for termination of provider contracts, allows for access to specialty providers, includes continuity of care provisions for ongoing care with providers outside of the plan, and requires the commissioner of health to determine that there are sufficient providers to meet the covered patients’ needs. “Willing provider” legislation has been proposed; the public health law would specify, “No HMO shall discriminate against any provider who is located within the geographic area of the health benefit plan and who is willing, capable, and can meet the terms and conditions for participation.”

Prescriptive Authority
NPs have full prescriptive authority, including Schedules II-V controlled substances. NPs may order drugs, devices, immunizing agents, tests, and procedures in accordance with the practice agreement and practice protocols without cosignature. NPs may receive and dispense pharmaceutical samples if appropriately labeled and handed directly to the patient. Prescription labels are labeled with the NP’s name. Midwives are authorized to prescribe and administer drugs, immunizing agents, diagnostic tests, and devices, and order laboratory tests limited to the practice of midwifery; they can dispense pharmaceutical samples.

North Carolina

http://www.ncbon.org

Legal Authority
The North Carolina BON and the North Carolina BOM jointly grant NPs authority to practice and regulate their practice. CRNAs and CNSs are regulated by the BON only. APRNs are defined as NPs, CRNAs, CNSs, and CNMs. According to the North Carolina Nurses Association, NPs legally practice under a supervisory relationship with a physician; however, this is referred to as a collaborative practice. Collaborative practice must include a written collaborative practice agreement (CPA) with a physician for continuous availability and ongoing supervision, consultation, collaboration, referral, and evaluation. After the first 6 months of NP practice, in which documented face-to-face meetings are required, NPs and physicians may meet by phone or electronically. The CPA also includes the drugs, devices, medical treatments, tests, and procedures that may be prescribed, ordered, and performed by the NP as well as a plan for emergency services. The supervising physician does not have to be on site. The NP shall be prepared to demonstrate to the BON or BOM the ability to perform medical acts as outlined in the CPA. NP scope of practice is defined in both statute and regulation (21 NCAC 36.0800.0814). NPs are not recognized as “primary care providers” and North Carolina statutes do not contain “any willing provider” language. State law does not prohibit NPs from holding admitting and hospital privileges; however, these are granted on a facility-by-facility basis. Now NPs must have a master’s degree in nursing or in a field with primary focus on nursing and national board certification is required to enter into practice. CRNAs are regulated solely by the BON and do not have prescriptive authority. CNMs have their own separate statute and are regulated by a midwifery joint committee. NPs recognize and SOP is regulated by the BON, but does not include prescriptive authority. CNSs with master’s degrees in psychology/mental health may independently practice psychotherapy. All APRNs are allowed to form corporations with physicians; however, CRNAs can only incorporate with anesthesiologists.

Reimbursement
FNPs receive Medicaid reimbursement at 100% of the physician rate for primary care activities. NPs who are enrolled in mental health programs receive 85% of the physician rate. CHAMPUS also reimburses NPs. Statutory authority for third-party reimbursement for NPs provides direct reimbursement to NPs for ser-
vices within their scope that are reimbursable to a non-nurse provider. “No Discrimination in the Selection of Providers,” patients may choose services from a provider list that includes APRNs. The section, “Provider Directory Information,” requires that every health benefit plan use a provider network directory that includes all types of participating providers, including APRNs, upon participating providers’ written request.

**Prescriptive Authority**
NPs and CNMs have full prescriptive authority, including Schedules II-V controlled substances that are identified in their CPA. Dispensing may be done under specific conditions and if a dispensing license has been obtained. NPs may refill legend drugs up to 1 year and may write controlled substance prescriptions for 30 days; NPs may not refill any controlled substances. NPs with controlled substances in their collaborative practice agreements must obtain a DEA number (in addition to their prescribing number issued at the time of their approval as NPs). Prescription labels include the NP name only.

**North Dakota**
http://www.ndbon.org

**Legal Authority**
The North Dakota BON grants APRNs authority to practice and regulates their practice. APRNs are defined as NPs, CNSs, nurse midwives (NMs), and NAs. NPs practice in collaboration with a physician in North Dakota for prescriptive authority only. The SOP for an NP is based upon the Decision-Making Model and as defined in specialty certification. NPs are required to submit an SOP statement for review by the BON to apply for and renew their APRN license. APRN applicants for initial licensure must have a master’s degree with completion of an advanced practice track and national board certification.

**Reimbursement**
FNPs, PNP, and NMs receive Medicaid reimbursement at 75% of the physician rate and NMs at 85% of physician rate. BCBSND reimburses CNMs, NMs, CNSs, and NPs based on the lesser of the 1) provider’s billed charges or, 2) 75% of the BC/BS physician payment system(s) in effect at the time services are rendered. Any certified NP is eligible for a Medicaid reimbursement for health services provided in the third-party reimbursement authorizes reimbursement at 75% of the BC/BS physician payment system(s) in effect at the time services are rendered.

**Prescriptive Authority**
Authorized APRNs may prescribe legend drugs and Schedules II-V controlled substances. For prescriptive authority, the APRN must submit a statement to the BON addressing methods and frequency of the collaboration for prescriptive practices, which must occur as client needs dictate but no less than once every 2 months; documentation methods of the collaboration process regarding prescriptive practices; and alternative arrangements for collaboration regarding prescriptive practices in the absence of the physician. Communication between the APRN and physician must occur at least once every 2 months. An affidavit from the physician must be submitted, acknowledging the manner of review and approval of the planned prescriptive practices and that the APRN’s SOP is “appropriately related” to the collaborating physician’s specialty. The collaborative arrangement requirement is solely for prescriptive authority. APRNs with prescriptive authority may apply for a DEA number.

**Ohio**
http://www.nursing.ohio.gov

**2005 Legislative Accomplishments**
Legislation was passed and signed into law in December 2004 protecting the title, “Advanced Practice Nurse,” which includes CNPs, CRNAs, CNMs, and CNSs.

**Legal Authority**
The Ohio BON grants APNs authority to practice and regulates their authority. APNs are defined as CNPs, CRNAs, CNMs, and CNSs. Legal authority to practice requires a collaborative practice arrangement between a physician and a CPA. ANPs are also statutorily recognized as “primary care providers” and are currently authorized to admit patients or hold hospital privileges. The Ohio Nurses Association reports that legislation has been introduced to allow hospitals to recognize CNPs, CRNAs, and CNSs as eligible for admitting privileges at the time of print. Applicants for licensure must have a master’s degree in nursing or a related field that qualifies the individual to sit for the national certifying exam. Certification from a national certifying body is also required to enter into practice.

**Reimbursement**
Ohio’s Medicaid program recognizes CNPs certified in family, adult, acute care, geriatric, neonatal, pediatric, women’s health, and OB/GYN, CNMs, CRNAs, and CNSs certified in gerontology, medical/surgical, and oncology nursing specialties. Managed care organizations vary on empanelment. There are no legislative restrictions for an APN being listed on managed care panels; however, insurance companies are statutorily mandated to reimburse CNMs. Workers’ compensation continues to reimburse CNPs, CRNAs, and CNSs.

**Prescriptive Authority**
Ohio state law grants full prescriptive authority to qualified CNPs, CNMs, and CNSs on a voluntary basis. A separate approval process is required to apply for prescriptive authority. To qualify, the nurse must hold current RN and APN licensure, a master’s degree, a standard care arrangement with their collaborating physician, and an acceptable course in pharmacology completed within the past 3 years. APRNs prescribe under their own authority as soon as the certificate is received. The first certificate is an “externship” certificate to prescribe (CTP-E). During the 1,500-hour externship, the APN prescribes under the supervision of a collaborating physician. The externship must have 500 hours direct supervision, meaning the physician must be available on site; the remaining hours consist of indirect supervision (the physician must provide timely reviews of prescriptions and prescribing practices). APNs who prescribe in another state and are moving to Ohio may receive credit for up to 1,000 hours of indirect supervision for prior prescribing within the past 3 years. Upon externship completion, the APN applies for the CTP. At this stage, the APN prescribes within the collaborative arrangement. Compliance with further quality assurance measures is also required. By law, the interdisciplinary Committee on Prescriptive Governance, comprised of four APNs, four physicians, and two pharmacists, develops and revises the formulary. Schedules II-V controlled substances are included on the formulary. Schedules II-V controlled substances are limited to the care of terminally ill patients after physician-initiation and only for a 24-hour period. The formulary lists (1) permitted drugs, (2) drugs excluded from use, (3) physician-initiated drugs that can be renewed or adjusted, and (4) drugs with special parameters. APNs are not permitted to prescribe newly released drugs until the committee has reviewed them, and those who wish to prescribe drugs for off-label use must include parameters for off-label use in the standard care arrangement. The DEA issues continued on p. 33.
numbers to CTP-E and CTP holders. Pharmacists log the prescription by nurse prescriber, not by physician. The BOP and BON agree that the nurse with Rx authority may request, receive, sign for, and distribute sample medications within their scope and within the formulary. According to the law, (1) no fee may be charged for a sample, (2) only a 72-hour supply (or smallest commercially available size) may be dispensed, and (3) samples of controlled substances may not be dispensed.

Oklahoma

http://www.lsbon.state.ok.us
http://www.ok.gov/nursing

2005 Legislative Accomplishments

Oklahoma ARNPs now have authority to certify an applicant with either temporary or permanent disability to meet criteria for the Department of Safety to grant a detachable placard indicating such physical disabilities.

Legal Authority

The Oklahoma BON grants APNs authority to practice and regulates their practice. APNs are defined as ARNPs, CNMs, CNSs, and CRNAs. ARNPs function independently with the exception of prescriptive authority, which requires supervision by a physician. APNs practice within an SOP as defined by the NPA. The SOP for an ARNP is defined in regulation and is further identified in specialty categories that delineate the population served such as adult ARNP, school ARNP, family ARNP, etc. ARNPs are listed as “primary care managers” in the Oklahoma Medicaid system. Authorization to admit patients or hold hospital privileges was not reported in this survey. ARNPs and CNSs must hold a master’s degree in nursing and be nationally board certified to enter into practice.

Reimbursement

Oklahoma’s Medicaid plan includes ARNPs as “primary care managers.” State law does not mandate reimbursement of ARNPs, however, the Oklahoma State and Education Employees Insurance company does recognize ARNPs as providers. Negotiation continues with other third-party insurers.

Prescriptive Authority

The BON regulates optional prescriptive authority for ARNPs, CNSs, and CNMs, which includes controlled substances Schedules III-V. Physician supervision is required for the prescriptive authority portion of advanced practice. Prescribing parameters include: (1) not be on the exclusionary formulary approved by the board, (2) must be within the ARNP, CNM, and CNS SOP, (3) include Schedules III-V controlled substances (7-day supply) if state narcotics and DEA registrations are obtained, and (4) include signing to receive drug samples. ARNPs, CNMs, and CNSs must have 45 contact hours or 3 academic hours of pharmacology in the 3 years immediately preceding the initial application for Rx authority and 15 contact hours or 1 academic hour every 2 years for renewal. CRNAs have authority to “order, select, obtain, and administer legend drugs, Schedules II-V controlled substances, devices, and medical gases, when engaged in preanesthetic preparation and evaluation, anesthesia induction, maintenance and emergence, and postanesthesia care.” Regulation is by the BON. The CRNA functions under the supervision of a medical physician, DO, podiatric physician, or dentist licensed in Oklahoma and under conditions in which timely on-site consultation by such medical physician, DO, podiatric physician, or dentist is available. CRNAs must obtain state narcotics and DEA registrations to order Schedules II-V controlled substances.

Oregon

http://www.osbn.state.or.us

2005 Legislative Accomplishments

SB 880 was signed into law, which amends several code sections to include “Nurse Practitioner” language. For more information, log on to http://www.leg.state.or.us. These provisions are effective January 2006. Also, SB 460-B passed, authorizing CNs to prescribe medications, including Schedules II-V controlled substances, using the same formulary as the NPs. These provisions will require rule-making and DEA authorization.

Legal Authority

The Oregon BON grants APNs authority to practice and regulates their practice. APNs are defined as NPs, CNSs, and CRNAs. Nurses in all three categories of advanced practice must be credentialed with a certificate by the BON. APNs in Oregon are independent and are not required to have a collaboratory or supervisory relationship with a physician. SOP is defined in regulation, Division 50 of the Nurse Practice Act. NPs are statutorily recognized as “primary care providers” and permissive statutes allow for NP hospital privileges. NPs may, however, be refused privileges only on the same basis as other providers. A master’s degree is required for all categories of advanced practice; however, national board certification is not required to enter into practice in Oregon.

Reimbursement

NPs are entitled, by law, to reimbursement by third-party payers. APNs are designated as PCPs on several HMO and managed care plans. Medicaid reimburses NPs for services within their SOP at the same rate as physicians. Numerous administrative rules and statutes include NPs, such as special education physical examinations (Department of Education) and chronically ill and disabled motorist examinations (Department of Motor Vehicles).

Prescriptive Authority

Regulation of Rx authority is under the sole authority of the BON. The BON determines the formulary from which NPs can prescribe, including Schedules II-V controlled substances. The NP formulary is based on Drug Facts & Comparisons; new drugs are added to the formulary at each BON meeting. Criteria for inclusion include (1) Is the drug appropriate for NP SOP? (2) Would the NP use the drug? and (3) Is the drug FDA approved? Oregon has legislated independent or plenary authority for NPs to prescribe, so NPs are able to obtain DEA numbers. NPs with prescription writing authority may receive and distribute prepackaged complimentary drug samples. NPs may apply to the BON for drug dispensing authority if the NP’s patients have financial or geographic barriers to pharmacy services. NPs do not have authority to prescribe under the physician-assisted suicide law. Only physicians can authorize medical marijuana use.

Pennsylvania

www.dos.state.pa.us/nurse

2005 Legislative Accomplishments

Reinterpretation of current regulations revised the term “physician” to include both medical and osteopathic physicians for the purposes of collaboration when prescribing medications. This went into effect June 1, 2005.

Legal Authority

The Pennsylvania BON grants CRNPs authority to practice and regulates their practice. A CRNP performs the expanded role in collaboration with a medical or osteopathic physician. Collaboration is defined as a process in which a CRNP works with one or more physicians to deliver healthcare services within the scope of the CRNP’s expertise. The physician(s) may or may not be on site and collaboration is incorporated in the following ways: (1) immediate availability through voice or direct communication, (2) a predetermined plan for emergency services, and (3) availability on a regularly scheduled basis for consultation, chart review, and “establishing and updating standing orders, drug and other medical protocols,” and “periodic updating in medical diagnosis and therapeutics.” The CRNP’s SOP is defined in statute; however, CRNPs are not recognized as “primary care providers.” The Pennsylvania Department of Health authorizes a hospital’s governing body to grant and define the scope of clinical privileges to individuals, with advice of the medical staff. After February 5, 2005, CRNPs must

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www.tnpj.com The Nurse Practitioner • January 2006 33
have a master’s degree and pass a national certification examination; CRNPs without a master’s degree/certification are accepted if their CRNP was granted prior to the law’s effective date. CNSs are not specifically defined or regulated beyond the RN SOP. The BON does not track, monitor, or license CRNAs. The BOM licenses and regulates CNMs.

**Reimbursement**

Third-party reimbursement is available for the CRNP, CRNA, certified enteral stomal therapy nurse, certified community health nurse, certified psychiatric/mental health nurse, and certified CNS, provided the nurse is certified by a state or a national nursing organization recognized by the BON. Medicaid reimburses CRNPs and CNMs at 100% of physician payment for certain services. The State Department of Health allows HMOs to recognize CRNPs as primary care gatekeepers.

**Prescriptive Authority**

The BON confers prescriptive authority, including Prescriptions II-V controlled substances, to CRNPs with a collaborating physician. Regulations allow a CRNP to prescribe and dispense drugs if the CRNP has successfully completed a minimum of 45 hours of course work specific to advanced pharmacology and if the prescribing and dispensing is relevant to the CRNP’s area of practice, documented in a collaborative agreement, and not from a prohibited drug category. The CRNP may write a prescription for a Schedule II controlled substance for up to a 72-hour dose if the CRNP notifies the collaborating physician within 24 hours. CRNPs may prescribe Schedules III-V medications for up to a 30-day supply, however, the physician must authorize a refill. CRNPs are authorized to request, receive, and dispense pharmaceutical sample medications. Prescription blanks must include the name and certification number of the CRNP and identify the collaborating physician. The collaborative agreement is a signed, written agreement between the CRNP and a collaborating physician and must identify the parties to the agreement; area of practice; specify the categories of drugs from which the CRNP may prescribe and dispense; specify conditions for prescribing a Schedule II controlled substance; and specify the circumstances and how often the collaborating physician will personally see the patient, be kept at the primary practice site, and be available for inspection.

**Rhode Island**

http://www.healthri.org/hsr/professions/n_pract.htm

**Legal Authority**

The Rhode Island BON grants APRNs authority to practice and regulates their practice. APRNs are defined as CRNPs, CRNAs, and Psychiatric and Mental Health Clinical Nurse Specialists (PCNSs). There are no requirements for physician collaboration to practice as a CRNP, with the exception of prescriptive authority. SOP is defined within the NPA. CRNPs are statutorily recognized as “primary care providers” in Rhode Island by the Medicaid managed care program. Nothing prohibits hospitals from granting admitting and hospital privileges to providers; however, privileging is granted by the facilities based upon individual policies. The minimum degree to enter into practice is a master’s degree in nursing and national board certification is required. CNMs have a separate law and separate R&R that are not under the BON. BON R&R define CNSs.

**Reimbursement**

State law allows for direct reimbursement of psychiatric CSs and CNSs. CRNPs and PCNSs practicing in collaboration with or employed by a physician, receive third-party reimbursement. United Healthcare has begun to empanel NPAs. The RiteCare Program (managed care program for persons eligible for Medicaid), allows CRNPs and CNMs to serve as primary care providers. CRNAs receive third-party reimbursement for services under the supervision of anesthesiologists or dentists.

**Prescriptive Authority**

Rhode Island requires a collaborative practice agreement for prescriptive authority. CRNPs are authorized to apply for controlled substance registration for privileges to prescribe legend and Schedules II-V controlled substances. Prescriptive authority registration requires 30 hours of pharmacy CE within 3 years prior to application, Advisory Committee approval, and written collaborative guidelines with a physician. A six-member Formulary Committee recommends what the drug formulary contains. The CRNP and collaborating physician or medical director develop practice guidelines, which determine the drugs that will be prescribed from the formulary; the practice guidelines are kept at the practice site and are updated annually. PCNSs have authority to prescribe certain legend medications and controlled substances from Schedule II classified as stimulants and controlled substances from Schedule V that are described in regulations. PCNSs prescribe in accordance with annually updated practice guidelines, written in collaboration with the medical director or physician consultant of their individual establishments. Draft guidelines “provide guidance to licensed healthcare facilities relating to the proper storage, security, and dispensing of medications.” The guidelines, referenced from state statutes, state that licensed practitioners with authority to prescribe medications may procure and dispense (including drug samples) legend medications and Schedules II-IV controlled substances if the practitioner has obtained the required state and federal registrations.

**South Carolina**

http://www.llr.state.sc.us/pol/nursing/

**2005 Legislative Accomplishments**

The BON has reported they are working on a housekeeping bill to clarify that only APRNs who prescribe Schedules III-V controlled substances will be required to obtain DEA registration.

**Legal Authority**

The South Carolina BON grants APRNs authority to practice and regulates their practice. APRNs are defined as an NP, CNM, or CNS. APRNs must have a collaborative relationship with a physician and may perform “delegated medical acts” in addition to nursing acts as defined by the BON. “Delegated medical acts” may be performed by APRNs pursuant to an approved written protocol between the nurse and physician, and are defined as “additional acts delegated by the physician that include formulating a medical diagnosis and initiating, continuing, and modifying therapies, including prescribing drug therapy under approved written protocols.” NPs who manage delegated medical aspects of care must have a supervising physician who can be accessed by electronic means, and operate within the “approved written protocols.” APRNs are legally authorized to admit patients to a hospital and hold hospital privileges; however, this is left up to the individual agency. APRNs must hold a master’s degree in nursing and national board certification in an advanced practice nursing specialty to enter into practice.

**Reimbursement**

All NPs, regardless of specialty, may apply for a Medicaid provider number, are paid 85% of the physician payment rate, and are recognized as “primary care providers.” The State Health and Human Services finance commissioner requires that NPs have current, accurate, and detailed treatment plans. Approximately 15 payers recognize, enroll, and directly reimburse APRNs for services provided.

**Prescriptive Authority**

APRNs have prescriptive authority, including Schedules III-V controlled substances, and prescribe according to practice agreement/protocol within the specialty area of the APRN. The BOP has opined that, “The supervising physician is not the prescriber. The NP prescribes independently of the supervising physician, has their own DEA registration, and must have a state and federal ID number.” The BON issues an identification number to the nurse authorized to prescribe. State law requires prescrip-
South Dakota

[http://www.state.sd.us/dci/nursing](http://www.state.sd.us/dci/nursing)

**Legal Authority**

The South Dakota BON and BOM jointly regulate the practice of CNPs and CNMs. APNs are defined as CNPs, CNMs, CRNAs, and CNSs. CNPs and CNMs practice in collaboration with a physician licensed in the state when performing overlapping functions between advanced practice nursing and medicine. On-site physician collaboration is required one-half day per week. CNSs are regulated by the BON and physician supervision is not required; however, prior to ordering durable medical equipment or therapeutic devices, CNSs must collaborate with a physician. CRNAs are regulated by the BON and perform acts of anesthesia in collaboration with a physician licensed in the state as a member of a physician-directed healthcare team. On-site supervision is not required. APNs are granted hospital privileges.

**Reimbursement**

CNPs and CNMs receive Medicaid reimbursement at 90% of the physician payment rate. CRNAs are reimbursed at the physician rate for services provided under Medicaid. State insurance law is silent regarding CNSs; however, CNSs may be reimbursed under specific plans. Medicaid reimbursement is allowed only if billed through a physician’s practice. CNPs and CNMs receive third-party reimbursement. State law mandates that CRNAs, CNPs, and CNMs be reimbursed on the same basis as other medical providers, assuming that the service is covered under the policy; CRNAs, CNPs, and CNMs may receive reimbursement when the service is covered under the policy and they are acting within their SOP.

**Prescriptive Authority**

South Dakota’s CNPs and CNMs may prescribe legend drugs and controlled substances. Schedules II-IV as authorized by the collaborating physician. CNPs and CNMs have two controlled substance registration options: (1) they may seek independent state registration and independent DEA registration in all schedules as authorized by their collaborative agreement; or (2) they may act as an agent of an institution, using the institution’s registration number to prescribe, provide, or administer controlled substances. Controlled substance authority is granted by separate application to the Department of Health following collaborative agreement approval by the BON and BOM. CNPs and CNMs may request and receive drug samples, provide drug samples, and provide a limited supply of labeled medications. Medications and sample drugs must be accompanied by written administration instructions and documentation entered in the patient’s medical record. The provision of drug samples or a limited supply of medications is not restricted, with the exception of Schedule II controlled substances, which are limited to a one-time, 48-hour supply. Therefore, the amount provided is at the professional discretion of the CNP or CNM and the collaborating physician. CNPs or CNMs who accept controlled substances, either trade packages or samples, must maintain a record of receipt and disposition. CRNAs and CNSs do not have Rx authority. CNSs may order and dispense durable medical equipment and therapeutic devices in collaboration with a physician.

Tennessee

[http://www.tnaonline.org](http://www.tnaonline.org)

**Legal Authority**

The Tennessee BON grants APNs authority to practice and regulates their practice. APNs are defined as NPs, CNMs, CRNAs, or CNSs. APNs meeting requirements for prescriptive authority are eligible for a certificate that is designated “with certificate of fitness.” APNs must hold a current RN license in Tennessee or a compact state if home state is a compact state. APNs who prescribe must have protocols that are jointly developed by the APN and the supervising physician. Medical Board rules that govern the supervising physician of the APN prescriber are jointly adopted by the BOME and BON. Physicians who supervise APN prescriber practices are not required to be on site, but must personally review and sign 20% of the charts within 30 days. CRNAs and CNSs are defined in the hospital licensure rules, which also provide that the medical staff may include CNMs; CNSs are not precluded from admitting a patient with the concurrence of a physician member of the staff. NPs have admitting and clinical privileges in Medicare critical access hospitals; however, privileges for NPs are not addressed in other hospital licensure rules and these privileges are inconsistent across the state.

**Reimbursement**

Tennessee private insurance laws mandate reimbursement of APNs. A managed care antidiscrimination law prevents managed care organization discrimination against APNs (specifically CNPs, CNSs, CNMs, and CRNAs) as a class of providers. However, not all organizations are, as of yet, credentialing and accepting APNs into their network. This is a major issue being addressed by TNA and private, APN practice owners. BC/BS credentials APNs in most of their programs and provides 100% reimbursement to primary care NPs in the TennCare program; BC/BS also reimburses CNMs and CRNAs. Other managed care organizations participating in the TennCare program also credential APNs and assign an established patient panel upon individual review of specialty.

**Prescriptive Authority**

APNs that have a BON-issued certificate to prescribe may prescribe legend and Schedules II-V controlled substances. A certificate to prescribe requires a master’s or doctorate degree in nursing, preparation in specialized practitioner skills at the master’s, postgraduate, or postdoctoral level, three academic quarter hours of pharmacology or its equivalent, and current certification in the appropriate nursing specialty area. APNs meeting these qualifications may sign prescriptions and/or issue medications, including Schedules II-V medications under protocols in any practice site. The APN’s script pad must have the preprinted name and address of the supervising physician and of the APN, however, the name of the physician is no longer required on the signature line. NPs may request, receive, and issue pharmaceutical samples.

Texas


**2005 Legislative Accomplishments**

Nine bills became law that specifically mentioned APNs. One of the bills establishes a pilot healthcare clinic in a state office complex staffed by an NP. Many other laws refer to “practitioners” or “healthcare providers,” thus including APNs. Also, a provision in a Medicare reform bill requires managed care companies to contract to provide healthcare for Medicaid clients to include APNs as PCPs.

**Legal Authority**

The Board of Nurse Examiners is authorized by the NPA to regulate APNs. Although RNs may practice based on a multi-state licensure privilege, APNs must apply for authorization to practice as an NP, CNM, CRNA, or CNS. As of January 1, 2006, unless NPs receive a waiver, the BNE will only recognize NPs educated in nine specialties for legal entry into practice: 1) adult acute care; 2) pediatric acute care; 3) adult; 4) family; 5) geriatric; 6) neonatal; 7) pediatric; 8) psychiatric-mental...
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Reimbursement

All APN categories are eligible for direct Medicaid reimbursement at 85% of physician payment rates. Based on a rider in the 2005 Appropriations Bill and a statement of legislative intent, it is anticipated the Medicaid program will soon require APNs to bill their services under the APN’s own provider number and increase the APN’s reimbursement rate to 92% of the physician’s fee. (Formerly, physicians were permitted to bill for APN services provided under jointly developed protocols to be billed as a physician service at 100% of the physician rate.) Some programs such as Texas Health Steps (EPSDT) reimburse all providers at the same rate. Most NP categories must have a Medicare provider number before they will be granted a Medicaid number. NPs can be PCPs in the primary care management model for Texas Medicaid managed care. In 2005, a provision in a Medicaid reform bill required managed care companies who contract to provide healthcare for Medicaid clients to include APNs as PCPs. All HMOs and PPOs are required to list an APN on provider panels if the APN’s collaborating physician is on the panel and the physician requests that the APN also be listed.

Prescriptive Authority

APNs may prescribe controlled substances Schedules III–V. APNs must obtain a prescriptive authorization number from the BNE. To receive the number, the nurse must have full authorization to practice as an APN in Texas and meet certain additional educational requirements. To use prescriptive authority, APNs must practice in a qualifying site and a physician must delegate prescriptive authority in that site using general delegation protocols. Sites qualifying for prescriptive authority are (1) sites that serve medically underserved populations, (2) physician primary practice sites, (3) physician alternate practice sites; and (4) facility-based practices in hospitals or long-term-care facilities. The delegating physician must spend some time at each site with the APN, but that time varies from once every 10 business days in a medically underserved population site to the majority of the time in a physician’s primary practice site. The Medical Board has authority to waive some of the supervisory and site requirements for physicians who delegate prescriptive authority. The BNE is not part of this process. Physicians may delegate prescriptive authority for Schedules III–V controlled substances with the following limitations: (1) APNs may only Rx a maximum 30-day supply; (2) the APN must consult with the physician before authorizing a refill; (3) APNs may not Rx controlled substances to a child under 2 years without physician consultation; and (4) physician consultation must be noted in the chart. APNs that prescribe controlled substances must have a permit from the Texas Department of Public Safety and a DEA number. APNs with prescriptive authority may request, receive, possess, and distribute samples of drugs they are authorized to prescribe.

Utah

http://www.dopl.utah.gov/nurse.html

2005 Legislative Accomplishments

HB 25 Direct Entry Midwife Act provides for the licensing of Direct Entry Midwives by the Utah Division of Occupational and Professional Licensing; provides for definitions relating to the practice of Direct Entry Midwifery; creates the licensed Direct Entry Midwife Board and sets forth its membership and duties; requires the division to establish a Licensed Direct Entry Midwife Formulary Committee and licensed Direct Entry Midwife formulary to define which prescription drugs can be obtained and administered by licensed but non-certified Direct Entry Midwives and to provide guidelines for their use. Direct Entry Midwives who are not CNMs are authorized to use certain prescription drugs for delivering babies at home unsupervised by a trained professional. It was strongly opposed by the Utah Nurses Association and Utah Nurse Practitioners Government Relations Committee, and by the Utah Medical Association. Also, HB 42 Medical Recommendations for children makes it illegal for school employees, including RNs and APNs, to make certain medical recommendations to parents about their children’s health status, including recommending a psychiatric evaluation, counseling and/or use of psychotropic drugs. It passed by a fair margin, but was vetoed by the governor. It was strongly opposed by the Utah Nurses Association and the Utah Nurse Practitioners Government Relations Committee.

Legal Authority

The Utah BON, under the Division of Occupational and Professional Licensing (DOPL) grants authority to practice and regulates the practice of APRNs and CRNAs. APRNs are defined as NPs, psychiatric/mental health specialists, and other CNPs. CRNAs are not recognized in state law as APRNs; CRNAs hold separate licensure and are regulated under the same NPA but under a different classification. CNMs are regulated by a separate practice act and CNM board. APRNs practice independently except for the act of prescribing controlled substances Schedules II–III, where physician collaboration is required. The APRN SOP is defined by set standards from each national professional specialty organization, as specified in the NPA. APRNs are not statutorily prohibited from admitting patients and holding hospital privileges; however, this is decided upon by the individual institution. All APRNs must be master’s degree prepared and nationally certified to obtain licensure. During the 2004 legislative session, the Utah Legislature was the first legislature to adopt the APRN compact.

Prescriptive Authority

APRNs and CNMs have prescriptive authority for all legend drugs and devices, including Schedules IV–V controlled substances, within their SOP. A consultation and referral plan is only needed if prescribing Schedules II or III controlled substances. CRNAs do not require a consultation or referral plan for their practice. CRNAs may order and administer drugs, including Schedules II–V controlled substances, in a hospital or ambulatory care setting; they may not provide prescriptions to be filled outside the hospital. APRNs, CRNAs, and CNMs receive a DEA number after passing a controlled substance examination and obtaining a state-controlled substance license. APRNs and CNMs may sign for and dispense drug samples, and the NP name is listed on the prescription label.

Vermont

http://www.vtprofessionals.org/nurses/

Legal Authority

The Vermont BON grants APRNs authority to practice and regulates their practice. APRNs include, but are not limited to, NPs in adult, pediatrics, family and women’s health, CNMs, CRNAs, and CNSs in psychiatric health. The
BON endorses other CNSs under certain circumstances. The APRN performs medical acts independently, within a collaborative practice with a physician, under practice guidelines that are mutually agreed on between the APRN and collaborating physician. The practice guidelines must be reviewed and signed annually, and filed at the workplace. APRN SOP is defined in statute, and NPs, legally recognized as “primary care providers,” are endorsed by the BON to perform acts of medical diagnosis and to prescribe medical, therapeutic, or corrective measures under the R&R. CNSs in psychiatric health do not need a collaborative physician if they do not have prescriptive privileges. APRNs are authorized to admit patients to a hospital and hold hospital privileges, according to agency protocols. APRNs are required to have a master’s degree in nursing and hold national board certification to enter into practice.

Reimbursement
BC/BS reimburses psychiatric NPs using a provider number. All NPs receive Medicaid reimbursement at 100% of physician payment. The state Medicaid program is implementing an enhanced reimbursement to physicians who care for patients covered by both Medicare and Medicaid. The medical case management fee rules do not include NPs as eligible PCPs. Although legislation requiring or prohibiting third-party reimbursement does not exist, insurance companies may reimburse NPs depending on policies.

Prescriptive Authority
APRNs have full prescriptive authority, including Schedules II-V controlled substances within their practice guidelines. APRNs have the same privileges dispensing and administering drugs as physicians. NPs register for their own DEA numbers and prescriptions are labeled with the APRN’s name.

Virginia
http://www.dhp.state.va.us

Legal Authority
The Virginia BON and BOM have joint statutory authority to regulate licensed nurse practitioners (LNPs). LNPs are defined as NPs, CNMs, and CRNAs. CNSs are registered solely by the Virginia BON. The passage of House Bill 1479 eliminated the requirement for collaboration and a Joint Practice Agreement with a physician to prescribe controlled substances. The Act also eliminated the provision of CRNAs from prescribing controlled substances.

Reimbursement
The Virginia BON and BOM have joint statutory authority to regulate licensed nurse practitioners (LNPs). LNPs are defined as NPs, CNMs, and CRNAs. CNSs are registered solely by the Virginia BON. The passage of House Bill 1479 eliminated the requirement for collaboration and a Joint Practice Agreement with a physician to prescribe controlled substances. The Act also eliminated the provision of CRNAs from prescribing controlled substances.

Prescriptive Authority
Authorized LNPs may prescribe all legend drugs, including Schedules III-V controlled substances as defined in the Practice Agreement. A Practice Agreement developed between the NP and the supervising physician is submitted to the joint boards; this agreement lists the drug categories the NP will prescribe. Furthermore, NPs may only prescribe legend drugs if “such prescription is authorized by the written agreement between the NP and physician.” The prescription may contain only the NP’s name, but the patient must be informed in writing of the name and address of the supervising physician. Each physician may have a Practice Agreement with four NPs in both for-profit and nonprofit sites. Physicians who supervise NPs require periodic site visits. The joint regulations of the BON and BOM include requirements for continued NP competency (for example, CE testing). The regulations also address ethics, standards of care, patient safety, the use of new pharmaceuticals, and communication with patients. LNPs may receive and dispense drug samples under an exemption to the state Drug Control Act, which states that the act “shall not interfere with any LNP with prescriptive authority receiving and dispensing to his own patients manufacturer’s samples of controlled substances and devices that he is authorized to prescribe according to his practice setting and a written agreement with a physician.”

Reimbursement
 Medicaid reimbursement is available to ARNPs at 100% of physician payment. Washington insurance code bans discrimination against RNs, podiatrists, chiropractors, and certain mental health professionals. Rules governing payment to, and inclusion of, nurses prohibit artificial reductions in the level of an indemnification benefit based on a patient’s choice of nursing services rather than those of other health providers. A difference in payment between a physician and a nurse who provide the same services must result from the “disparity of fees actually charged by medical doctors and registered nurses rather than from an arbitrary formula based on assumptions concerning the relative worth of physician-provided services versus nurse-provided services.” The law pertains to private insurers and healthcare service contractors. The Women’s Health Care Law allows women to directly access a women’s healthcare practitioner of their choice, without referral from another provider. The law applies to all insurance carriers regulated by the insurance commissioner and includes ARNP specialists in women’s health and midwifery.

Prescriptive Authority
All ARNPs who qualify to receive prescriptive authority have independent authority to prescribe according to (for example, CE testing). The regulations also address ethics, standards of care, patient safety, the use of new pharmaceuticals, and communication with patients. LNPs may receive and dispense drug samples under an exemption to the state Drug Control Act, which states that the act “shall not interfere with any LNP with prescriptive authority receiving and dispensing to his own patients manufacturer’s samples of controlled substances and devices that he is authorized to prescribe according to his practice setting and a written agreement with a physician.”

Reimbursement
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Prescriptive Authority
All ARNPs who qualify to receive prescriptive authority have independent authority to prescribe according to
substances. The dispensing of Schedules II-IV controlled substances is limited to a maximum 72-hour supply of the prescribed drug. Independent prescriptive authority entails an initial 30 hours of pharmacotherapy education within the area of practice obtained within the 2-year period immediately prior to application. Renewal of Rx authority every 2 years requires 15 hours of pharmacotherapy education within the area of practice. ARNPs are legally authorized to request, receive, and dispense pharmaceutical samples. Prescriptions are labeled with the ARNP's name.

West Virginia
http://www.wvnb.com

Legal Authority
The West Virginia BON grants authority to practice and regulates the practice of Advanced Nursing Practice (ANP). R&R define advanced practice for RNs. ANPs include NPs, CNsNs, CNMs, and CRNAs. ANP SOP includes the ability to assess, conceptualize, diagnose, analyze, plan, implement, and evaluate complex problems related to health. The ANP SOP does not require collaboration with a physician unless the ANP is prescribing. The CNM is required to practice in a collaborative relationship with a physician. CRNAs administer anesthesia in the presence and under the supervision of a physician or DDS. Hospital credentialing for ANPs is dependent upon individual hospital policy. All ANPs must have a Masters of Science in Nursing and hold national board certification.

Reimbursement
Family and pediatric NPs receive Medicaid reimbursement at 100% of the physician rate. State law requires insurance companies to reimburse nurses for nursing services, if such services are commonly reimbursed for other providers; however, R&R have not been promulgated. NPs and CNMs are defined as “primary care providers” (i.e., “a person who may be chosen or designated in lieu of a primary care physician who will be responsible for coordinating the healthcare of the subscriber”). The only restriction is that the NP or CNM must have a written association with a physician listed by the managed care panel; there is no requirement for employment or supervision by the physician. The Woman’s Access to Health Care Bill provided for direct access, at least annually, to a women’s healthcare provider for a well woman examination; providers include ANPs (CNMs, FNsPs, WHNPs, Adult NPs, GNPs, or PNPs).

Prescriptive Authority
Qualified ANPs have prescriptive authority, including Schedules III-V controlled substances. R&R specify that the ANP must meet specified pharmacology education requirements and certify that they have a written collaborative relationship with a physician or osteopath. The written collaborative relationship must include guidelines or protocols describing the individual versus shared responsibility between the ANP and physician, with periodic joint evaluation of the practice. No supervision requirement exists; ANPs are not required to be employed by a collaborating physician. The ANP works from an exclusionary formula. Schedules I and II controlled substances, anticoagulants, antineoplastics, radiopharmaceuticals, and general anesthetics are prohibited. A DEA number is issued directly to an ANP by the DEA. ANPs are authorized to sign for and provide drug samples.

Wisconsin http://www.drl.state.wi.us

Legal Authority
The Wisconsin Board of Nursing grants APRNs authority to practice and regulates their practice. APRNs are defined as NPs, CNsNs, CNMs, and CRNAs. NPs function under the NPA with a broad description of nursing practice. SOP is defined in statute and regulations, which cover the performance of delegated medical acts by an RN: (1) the RN must follow protocols or written or verbal orders; (2) as jointly determined by the RN and physician, the ability to perform the delegation is based on the RN’s education, training, and experience; (3) the RN must consult with the physician when the delegated medical act may harm the patient; and (4) the RN can perform the delegated act under general supervision—the physician does not have to be present in the facility. Hospital privilege laws are permissive, not prescriptive; therefore, some hospitals extend full admitting privileges to APRNs, others do not. A master’s degree in nursing and national board certification is required to enter into practice in Wisconsin.

Reimbursement
Medicaid reimbursement of 100% exists for specified reimbursable billing codes as submitted by all master’s degree prepared NPs or NPs certified by ANCC, NAPNAP, or NAACOG. Reimbursement is up to the maximum allowed for physicians billing for the same service. Qualified NPs are paid directly regardless of their employment site or arrangement. There are Medicaid bonuses for NPs working in certain areas or for certain pediatric visits. CHAMPUS reimburses NPs; home health RNs bill under their own provider number. Third-party reimbursement has not been addressed legislatively. Some managed care panels are open to NPs, but few allow NPs to be the primary care provider of record.

Prescriptive Authority
RNs may prescribe legend drugs and controlled substances as a delegated medical act under the NPA. APRNs may receive “Advanced Practice Nurse Prescriber” (APNP) certification from the BON for independent prescriptive authority. Eligible APRNs must be certified by a board-approved APRN national certifying body, have completed 45 contact hours in clinical pharmacology/therapeutics within the 3 years preceding application, pass an APNP jurisprudence examination, and hold a master’s degree in nursing or a related health field. DEA numbers are issued to APNPs. The APNP may prescribe Schedules II-V controlled substances and must comply with restrictions regarding prescribing amphetamines and anabolic steroids. Schedule II substances may only be prescribed as an adjunct to opioid analgesic compounds for the treatment of cancer-related pain, narcolepsy, hyperkinesis, drug-induced brain dysfunction, epilepsy, and depression refractory to other modalities, according to the BON.

Prescription drugs may be dispensed if the APNP is certified to prescribe; prepackaged doses may be dispensed independently if the nearest pharmacy is more than 30 miles away.

Wyoming
http://nursing.state.wy.us/

Legal Authority
The Wyoming BON grants APRNs authority to practice and regulates their practice. APRNs are defined as NPs, CNsNs, CRNAs, and CNsNs. APRNs are not required to have a collaborative or supervisory relationship with a physician. The SOP of an APRN is defined in statute, within the NPA, and includes prescriptive authority and management of patients. APRNs are statutorily defined as “primary care providers” and are legally authorized to admit patients to a hospital and hold hospital privileges. A master’s degree in nursing and national board certification are required to enter into practice as an APRN in Wisconsin.

Reimbursement
APRNs are authorized to receive Medicaid payments at 100% of physician payment. All primary care providers may receive third-party payment, however, policies differ among third-party payers.

Prescriptive Authority
BON-approved APRNs may independently prescribe legend and Schedules II-V controlled substances. APRNs are considered independent providers and register for their own DEA numbers. Additionally, APRNs who have prescriptive authority are legally authorized to request, receive, and dispense pharmaceutical samples. Prescriptions are labeled with the APNP name according to the Wyoming BON.