

AN NP EXCLUSIVE



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27th Annual APRN Legislative Update

Advancements continue for APRN practice

By Susanne J. Phillips, MSN, FNP-BC

As the tides of healthcare in the United States continue to change, advanced practice registered nurses (APRNs) are at the forefront of legislative history. This overview provides a snapshot of legislative and regulatory activity in 2014 as reported by state Boards of Nursing and nursing organizations representing APRNs.

Historic legislative efforts to improve practice authority, reimbursement, and prescriptive authority for advanced practice registered nurses (APRNs) highlight this year's Annual Legislative Update. During the past year, states made exceptional progress in moving APRN practice forward by increasing alignment with the Consensus Model for APRN Regulations: Licensure, Accreditation, Certification, and Education. In 2014, three states enacted legislation authorizing full practice authority following a supervised practice period after licensure and certification. One state successfully promulgated regulations requiring Medicaid to

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empanel and reimburse all recognized board-certified nurse practitioner (NP) specialties. Schedule II controlled substance (CS) prescriptive authority was added to the scope of practice for one or more APRN roles in two states. This overview provides a snapshot of legislative and regulatory activity as reported by state Boards of Nursing (BONs) and nursing organizations representing APRNs. The overview includes information regarding individual state practice authority, reimbursement information, and prescriptive authority information.

■ Updates to APRN practice authority

This update focuses on the practice of NPs; however, statutory and regulatory changes in the practice of other APRN roles are noted as reported through a survey of state BONs and professional associations. This year, respondents were also asked to identify authority to order home health. Although federal regulation currently prohibits this activity for Medicare recipients, a number of states have authorized this activity through statute or regulation to improve access for patients who are covered by other payers. The following summarizes successful legislative efforts of states' attempts to improve the practice of all APRNs.

Connecticut, Minnesota, and New York are the newest additions to the growing number of states authorizing full practice authority (FPA) for one or more APRN roles. Legislation passed in these states requires a supervised practice period following licensure and certification prior to FPA being granted. In **Connecticut**, certified nurse practitioners (CNPs) and clinical nurse specialists (CNSs) must practice in collaboration with a physician for 3 years, or a minimum of 2,000 hours prior to being granted FPA. **Minnesota** enacted Chapter 235, authorizing FPA to all four APRN roles. CNPs and CNSs must first complete a supervised 2,080-hour "post-graduate practice" period in collaboration with a licensed CNP, CNS, or physician. In **New York**, passage of the *Nurse Practitioners Modernization Act* eliminated the requirement of a written collaborative practice agreement for NPs who have practiced in collaboration with a physician for at least 3,600 hours; an attestation of collaboration with a physician must be filed following that period.

In **Alaska**, the CNS role is now recognized as an APRN, and the BON is awaiting statutory change to adopt the Consensus Model definition of all four APRN roles. **Arizona** reported NP authorization to order home health pursuant to Article 5 (RA-19-508) of the Rules of the State Board of Nursing. Additionally, coalition efforts are underway to sponsor legislation supporting adoption of additional

components of the Consensus Model, including removal of supervision for certain APRN roles. New legislation was not introduced in **Arkansas**; however, their BON did report that APRNs are authorized to order home health if the individual is educationally-prepared and it is within their certification (regulatory authority is not explicit); **California's** Nurse Practice Act (NPA) authorizes NPs to order home health pursuant to a standardized procedure.

Delaware enacted legislation increasing the number of APRNs appointed to the Delaware BON from one APRN to two APRNs representing different roles. Additionally, regulations were updated to include all four APRN roles and population focus, as well as a requirement for graduation from a graduate or post-graduate accredited program consistent with the Consensus Model. The **District of Columbia** BON reported they are drafting updates to regulations consistent with all four areas of the Consensus Model, which at the time of this report had not been released for public comment. Act 45, SLH 2014 was passed in **Hawaii**, which amended various laws to enable APRNs to practice to the fullest extent of their education and training, including authorization to certify disability, attest to fitness for driver's license renewal, and exempt an individual from required immunizations, among others. In addition, Act 46, SLH 2014 was enacted, replacing references to "APRN recognition" with "APRN licensure" in alignment with the Consensus Model.

During the past year, states made exceptional progress in moving APRN practice forward.



In **Illinois**, SB 3076 (Mulroe and Feigenholtz), a bill addressing advance directives, was passed to include provider-neutral language. By replacing "physician" with "practitioner," APNs, as defined in Illinois, are now authorized to write life-sustaining treatment orders and "do-not-resuscitate" orders utilizing the Do Not Resuscitate/Physician Order for Life-Sustaining Treatment (DNR/POLST) form. Illinois APNs are authorized to order home health for Medicaid recipients pursuant to Chapter R-200, Policy and Procedures for Home Health Agencies.

Indiana enacted two legislative provisions improving the practice of APRNs in that state. Public Law 58 was enacted, which provides for, among other things, the certified registered nurse anesthetist (CRNA) role to be included in Indiana's definition of an APN. Indiana now recognizes all four APRN roles, consistent with the Consensus Model.

Additionally, legislation passed authorizing any healthcare provider, including APRNs, registered in the Federal Motor Carrier Safety Administration's National Registry of Certified Medical Examiners to perform a physical examination for school bus driver applicants. **Iowa's** NPA now affords title protection to ARNPs, as defined in Iowa. Stakeholders are working to lay the foundation for future legislative and regulatory amendments moving toward alignment with the Consensus Model. The Iowa BON does not have specific Rules and Regulations (R&Rs) to address this issue; however, Iowa ARNPs have independent practice and state statutes,

but plans are underway to introduce new legislation with a supervised practice period prior to FPA in 2015. Interestingly, new legislation was adopted in Missouri creating a new provider group called the "assistant physician." This new provider group consists of medical school graduates who have not completed their residency or board certification but are authorized to provide healthcare services in underserved areas of Missouri under similar procedures as an APRN. **Nebraska's** legislature passed LB 916 (Crawford), eliminating the requirement for an integrated practice agreement between a physician and



Connecticut, Minnesota, and New York are the newest states authorizing FPA for one or more APRN roles.

CNP, among other changes; however, in an unprecedented move, Governor Heineman vetoed the legislature's unanimous vote, claiming he would have signed the bill if it would have required a 4,000-hour supervised practice period prior to FPA. Nebraska's NPA does authorize NPs to order home

and regulations do not expressly prohibit this activity. Similar to California, **Kansas** reports their APRNs are authorized to order home health if included in the collaborative practice agreement, although there is no explicit statutory or regulatory authority. Although **Louisiana** did not report legislative or regulatory changes in 2014, the BON plans to propose rules to authorize APRNs from other states to expeditiously obtain a temporary permit and prescriptive authority in times of a disaster. In **Kentucky**, Medicaid regulations were adopted to remove the "4 visits per patient/per year" restriction for Psychiatric/Mental Health NPs; however, this limit remains for other APRN roles, as it does for all physicians who are not psychiatrists. **Maryland's** Secretary of Health and Mental Hygiene has adopted new regulations for certified nurse midwives (CNMs), including the elimination of the collaborative plan and requirement for attestation of collaboration. A coalition will be working on future legislation to remove the attestation requirement for other APRNs.

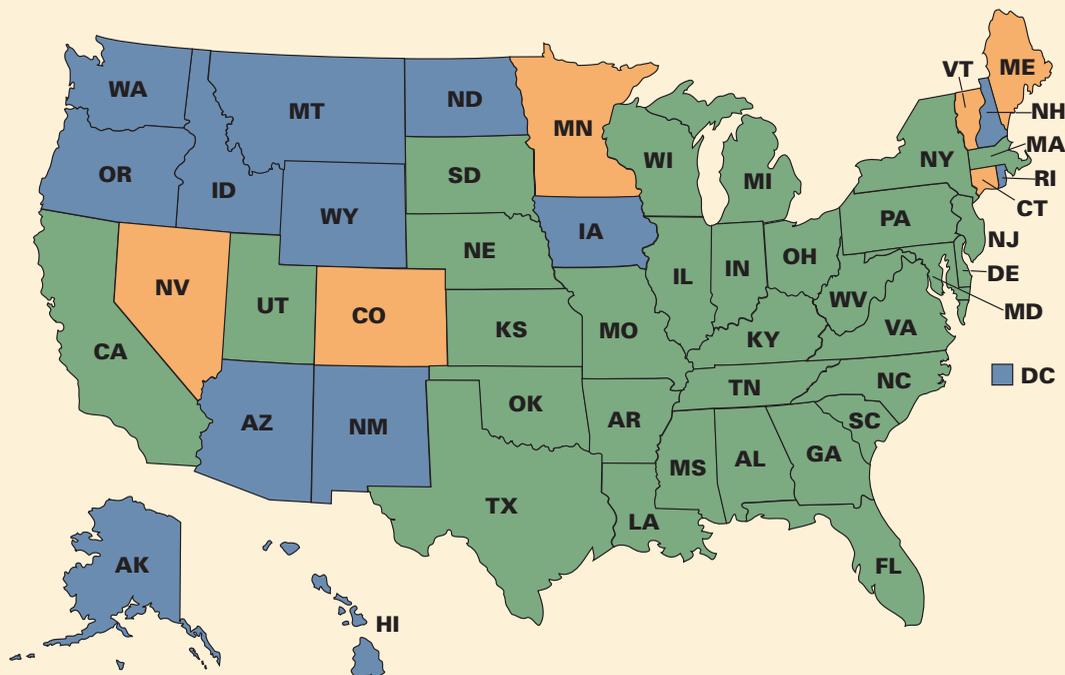
In **Minnesota**, APRNs are now required to obtain national certification and licensure consistent with the Consensus Model. The supervised "postgraduate practice" requirement previously referenced at the beginning of the article does not apply to CNMs or CRNAs. Minnesota plans to update regulations consistent with the Consensus Model in the coming year. **Missouri** passed HB 1779 (Riddle), permitting an APRN in collaborative practice with a physician to order physical or chemical restraints, isolation, or seclusion for a patient, resident, or client of a mental health facility. HB 1491 and SB 659 were introduced to adopt APRN language consistent with the Consensus Model, including APRN licensure, scope of practice (SOP) definition, prescriptive authority, and educational requirements. These

health by regulatory SOP but acknowledges the limitations posed by Medicare and some third-party payers.

Effective February 2014, **Nevada's** regulations incorporate the APRN title and includes the NP, nurse midwife (NM), and CNS roles. CRNAs are not included in the APRN definition. **North Carolina** is in the process of writing rules that will require mandatory BON recognition of CNS practice at the APRN level (currently voluntary) and amend education, accreditation of programs, and national certification requirements in accordance with the Consensus Model; if approved, the regulations will be effective January 2015 with implementation July 2015. The *Modernize Midwifery Practice Act* was submitted to the North Carolina legislature under recommendations from the Joint Legislative Oversight Committee to remove significant barriers that limit midwifery SOP. The bill is in committee at the time of this report, and movement or successful passage will be reported in the next annual update. The BON has reported that APRNs are authorized to order home health, noting no state regulations exist restricting or prohibiting this activity. **Oklahoma** reported regulatory amendments, including the deletion of the requirement for an APRN to submit their Drug Enforcement Administration (DEA) number in writing to the BON. In emergency rules [OAC 485:10-15-5 (b)(4)(D) and OAC 485:10-15-5 (c)(5)(D)] submitted to the Governor, regulation allows for the submission of evidence of current national board certification to meet requirements for APRN licensure reinstatement in addition to other reinstatement requirement options already included in the current rules.

Oregon reported passage of SB 1548 (Monnes Anderson), authorizing NP global signature authority. Oregon

Summary of Practice Authority for NPs*



■ NPs are regulated by a BONA and have full, autonomous practice and prescriptive authority without a requirement or attestation for physician supervision, delegation, consultation, or collaboration: AK, AZ, DC, HI, IA, ID, MT, ND, NH, NM, OR, RI, WA, WY

■ NPs are regulated by a BONA and have full autonomous practice and prescriptive authority following a post-licensure/certification period of supervision and/or collaboration: CO^{**}, CT[§], ME[&], MN[!], NV[#], VT[^]

■ NPs are regulated by a BONA or a combination of BONA and BOM oversight exists; requirement or attestation for physician supervision, delegation, consultation, or collaboration for authority to practice and/or prescriptive authority: AL, AR, CA, DE, FL, GA, IL[†], IN, KS, KY, LA, MA, MD, MI, MO, MS, NC, NE, NJ, NY[@], OH, OK, PA, SC, SD, TN, TX, UT, VA, WI, WV

[Washington, D.C., is included as a state in this table.]

* This table provides a state-by-state summary of the degree of independence for all aspect of NP scope of practice and prescriptive authority. This information may not apply to all APRN roles; see individual states for statutory and regulatory detail on scope of practice and prescriptive authority including CS authority. Scope of practice and prescriptive authority maps for CRNAs, CNMs, and CNSs can be found at the National Council of State Boards of Nursing website: <https://www.ncsbn.org/5397.htm>

** Full practice and prescriptive authority following a 3,600-hour (1800 + 1800) post-licensure practice period; attestation of physician collaboration required.

§ Full practice and prescriptive authority following a 3-year and a minimum of 2,000-hour post-licensure practice period.

& Full practice and prescriptive authority following a 24-month post-licensure practice period.

! Full practice and prescriptive authority following a 2,080-hour post-licensure practice period.

Full practice and prescriptive authority following a 2-year or 2,000-hour post-licensure practice period.

^ Full practice and prescriptive authority following a 2-year and 2,400-hour post-licensure practice period.

† APNs who are credentialed and privileged in a hospital or ambulatory surgical treatment center may practice without a written collaborative agreement.

@ Attestation of physician collaboration required after a 3,600-hour post-licensure practice period.

APRNs have been authorized to order home health since the late 1990s. SB 1063 (Vance and colleagues) referred to Pennsylvania’s Senate Consumer Protection and Professional Licensure Committee, provides for FPA for CRNPs, title definition of APRN and CNP, licensed independent practitioner status (LIP), PCP status, reimbursement by third-party payers, and other language consistent with the Consensus Model. This bill has not been voted on at the submission of this Update. CRNPs have authority to order

home health pursuant to PA Code § 21.282a (b) (8). Utah reported successful passage of HB 143 (Redd) removing a provision that requires an APRN applicant in the “psychiatric mental health specialty” to complete psychotherapy clinical practice requirements prior to licensure. Now, the applicants need to complete the psychotherapy clinical practice requirements before the first licensure renewal. An unsuccessful bill was introduced which, if passed, would authorize an APRN to prescribe a CS II or III without

Total Number of APRNs Reported by BONs and/or State Nursing Associations in 2014

State	Total APRNs	NPs	CNSs	CNMs	CRNAs
Alabama	4,533	2,802	88	20	1,623
Alaska	851	*	*	*	163!
Arizona	6,411	5,247	266	232	666
Arkansas	2,483	1,623	141	27	692
California	25,407	18,541	3,407	1,253	2,206
Colorado [∇]	5,221	3,510	665	343	703
Connecticut [∇]	4,084	3,869	*	215!	*
Delaware	1,384	878	135	35	336
District of Columbia	1,737	1,382	54	103	198
Florida	21,910	*	151	*	*
Georgia	8,787	6,409	386	478	1,829
Hawaii [∇]	1,080	*	*	*	*
Idaho [∇]	1,353	841	44	32	436
Illinois	9,052	5,846	1,017	420	1,769
Indiana [∇]	3,989	\$	\$	\$!
Iowa	2,692	1,943	90	111	548
Kansas	4,116	2,491	601	89	935
Kentucky	5,469	3,943	178	103	1,245
Louisiana	4,586	2,701	141	32	1,433
Maine	1,872	1,273	102	90	412
Maryland	5,618	4,537	∇	259	822
Massachusetts [∇]	10,001	7,367	(902)@	485	1,247
Michigan [∇]	7,902	∇	!	∇	∇
Minnesota	6,596	3,928	551	287	1,830
Mississippi [∇]	2,941	2,247	1	31	663
Missouri	7,651	5,344	390	114	1,803
Montana	1,029	740	43	56	190
Nebraska	2,067	1,383	96	43	545
Nevada	1,053	1,030	∇	23	146!
New Hampshire	1,974	1,546	@∇	105	313
New Jersey [∇]	6,250	*	*	! (BOME)	*
New Mexico	2,062	1,531	139	!	392
New York	19,822	19,822	!	!	!
North Carolina	8,412	5,199	93 [∞]	267	2,853
North Dakota	1,345	691	44	16	343
Ohio	12,318	7,565	1,596	361	2,796
Oklahoma	2,597	1,556	264	70	707
Oregon	3,894	3,070	204	^#	620
Pennsylvania	9,475	9,286	189	!	!
Rhode Island [∇]	1,036	607	119 [⊗]	69!	241
South Carolina [∇]	3,275	1,797	43	105	1,352
South Dakota [∇]	1,110	575	73	31	431
Tennessee	10,045	7,216	133	178	2,518
Texas	17,287 ^{&}	12,621	1,361	404	3,968
Utah	2,277		1,662	142	473
Vermont	651 ^{&}	533	46	62	70
Virginia	7,833	5,609	434	250	1,974
Washington	5,885	4,674 ^{**}	!	385	826
West Virginia	2,393	1,430	99	77	787
Wisconsin [∇]	3,875 ⁺	+	+	+	+
Wyoming	576	411	8	18	139

* Combined with total number of APNs/APRNs for that state
 ** Number includes PMH CNSs with NPs (New rules require all new applicants to be certified as Psychiatric NPs; CNS regulations pending)
 ! Not recognized as an APN/APRN by the BON and not included in Total APRNs
 ^ Included in total number of NPs
 ⊗ Psychiatric clinical nurse specialists recognized as APRNs only
 # Licensed/certified as NPs by the BON
 \$ BON Certifies only NPs, CNSs, and CNMs with prescriptive authority (Other APRNs practice but are not accounted for by the BON)
 + Certified as APNPs (Advanced Practice Nurse Prescribers)
 ∇ No update provided by BON / Update unavailable
 ∞ BON voluntary recognition only
 & Unduplicated APRN total

mandatory physician consultation. The Utah BON agrees that ordering home health is within the APRN SOP, although it is not specifically mentioned in the Act or Rule.

Vermont's BON reported they do not prohibit ordering of home health care by APRNs; however, they note that some programs may require physician authorization pursuant to federal regulation. Consistent with the Consensus Model, **Washington's** Nursing Care Quality Assurance Commission has opened the ARNP rules to add CNSs as a recognized ARNP role. Rules are in progress and are expected to be adopted in early 2015. An *Act Related to Suicide Prevention* (Chapter 71, 2014) passed requiring certain professionals certified or licensed under Title 18 RCW (nurses, chiropractors, naturopaths, physicians, physician assistants, physical therapists, and physical therapy assistants) complete a one-time, 6-hour training in suicide assessment, treatment, management, and referral. APRN groups do not agree with legislative mandates for specific areas of continuing education, and concern was expressed that lack of mental health resources is a major problem.

■ Updates to APRN reimbursement

Hawaii passed Act 45, SLH 2014 (SB 2492, SD1), which states that delaying investigation or payment of claims to an APRN is unfair or deceptive in general and with respect to cooperative corporations or indemnity arrangements. The Act also allows for a verbal request for expedited external review of the adverse action to be made if the insurance enrollee's APRN certifies that the health service/treatment that is the subject of the request would be significantly less effective if not promptly initiated. In **Utah**, regulations [DAR Section R414-1-5] have been promulgated, requiring Medicaid to empanel and reimburse all board-certified NP specialties (previously only family nurse practitioners [FNPs] and pediatric nurse practitioners [PNPs]). The *Licensed Nurse Practitioner Utah Medicaid Provider Manual* has also been updated. **Washington** reports Governor Inslee signed SB 6002 (Hill and Hargrove), maintaining an enhanced reimbursement for ARNPs for primary care services under the Medicaid Expansion through December 2014. This mirrors the Federal Enhanced Reimbursement available only to physicians and APRNs in states with supervisory requirements. Efforts to extend reimbursement through June 2015 were unsuccessful.

Illinois, Missouri, and Virginia all report active work on reimbursement issues in their states. The Illinois Society for Advanced Practice Nursing (ISAPN) is monitoring reimbursement changes due to the Patient Protection and Affordable Care Act. The Missouri Nurses Association (MONA) is pursuing clarification from insurance companies on reimbursement issues. The Virginia Council of Nurse Practitioners (VCNP) has constituted a Reimbursement Task

Force, which meets regularly with insurers and with the Insurance Commissioner.

■ Updates to APRN prescriptive authority

Alabama passed a new law in October 2013, Ala. Code § 20-2-260, authorizing the Board of Medical Examiners (BOME) to create a Limited Purpose Schedule II Permit (LPSP) for Physician Assistants (PAs), CRNPs, and CNMs to prescribe, administer, and authorize administration of CS II medications. The BOME adopted rules in October 2014 authorizing the process by which these providers may apply to the BOME for CS II authority pursuant to a collaborative practice agreement with a physician. **Connecticut** now authorizes full prescriptive authority for CNPs and CNSs following a 3-year and 2,000-hour minimum collaborative practice agreement period. **Kentucky** has moved closer to FPA by passing SB 7 (Hornback) into law which, among other provisions, allows an APRN to discontinue or be exempt from the Collaborative Agreement for Prescriptive Authority for Nonscheduled Drugs (CAPA-NS) requirement in limited circumstances after the APRN has prescribed under a CAPA-NS for 4 years in a certified population focus; clarifies that an APRN cannot be required to maintain a CAPA-NS after the 4 years but may choose to continue a CAPA-NS indefinitely. A Collaborative Agreement for Prescriptive Authority for Controlled Substances (CAPA-CS) is still required for CS authority.

In **Minnesota**, all APRNs will have independent prescriptive authority in January 2015. CNPs and CNSs are subject to the postgraduate practice period of 2,080 hours as previously described. Effective November 2013, the **Oklahoma** BON may issue prescriptive authority recognition by endorsement to an APRN licensed as a CNP, CNS, or CNM under the laws of another state if the applicant meets requirements set forth in statute [59 O.S. § 567.5a D]. **Texas** reported that subsequent passage of SB 406 (Nelson) in November 2013 authorizes APRNs with prescriptive authority to prescribe CS II medications in hospice settings and certain hospital settings. A prescriptive authority agreement is required and this bill changed the physician to APRN/PA ratio to 1:7 full-time equivalent. BON Rule 222 was amended to reflect those changes.

The State of **Maine** amended their *Maine Medical Use of Marijuana Act* authorizing CNPs, among other providers, to certify patients to receive therapeutic or palliative benefit from medical use of marijuana, among other provisions. This bill did not expand CNP prescriptive authority and does not authorize CNPs to prescribe marijuana. **NP**

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Alabama

www.npalliancealabama.org
 www.abn.state.al.us
 campaignforaction.org/state/alabama

Legal authority

APRNs are defined as advanced practice nurses (APNs) in Alabama and include the CNP (CRNP in statute), CNS, CNM, and CRNA roles. Although the BON has sole authority to establish the qualifications and certification requirements of APNs through R&Rs, the BON and BOME regulate the collaborative practice of physicians with CRNPs and CNMs, requiring them to practice with BON- and BOME-collaborative practice agreements. The collaborating physician and CRNP or CNM must sign written protocols. The term "collaboration" does not require direct, on-site supervision by the collaborating physician. The term does, however, require such professional oversight and direction as may be required by the R&R of the BOME and BON. The CRNP or CNM and collaborating physician shall be present in any approved practice site a minimum of 10% per month (if the CRNP or CNM is scheduled 30 or more hours per week) and a minimum of 10% on a quarterly basis (if scheduled less than 30 hours per week). "Remote practice site" is defined in rule, and the collaborating physician must visit each remote site at least quarterly. CRNP SOP is defined in statute and regulation; APNs practice in accordance with national standards and functions identified by the appropriate specialty-certifying agency in congruence with Alabama law.

Alabama does not recognize APNs as primary care providers (PCPs) and does not have "any willing provider" language in

statute. CRNPs are required to hold an MSN and national certification upon entry into practice with a few exceptions: Initial CRNP applicants are exempt from requirement for MSN on discretion of the BON if graduation was before 1996 in a post-BSN nurse practitioner (NP) program or graduation before 1984 from a non-BSN program preparing NPs. CRNAs must at minimum hold a master's degree from an accredited nurse anesthesia graduate program and be currently certified as a CRNA; CRNAs who graduated before December 31, 2003, are exempt from the master's degree requirement. CNS approval requires a master's degree or higher in advanced practice nursing as a CNS and national certification.

Reimbursement

There are no legislative restrictions for APNs on managed-care panels. The Alabama Medicaid Nurse Practitioner Program reimburses CRNPs; however, Medicaid does not reimburse for services provided in a hospital or ED. CRNPs are reimbursed through the Kids First Program. BC/BS will reimburse CRNPs and CNMs in collaboration with a preferred physician provider at 70% of the physician rate.

Prescriptive authority

CRNPs and CNMs may prescribe, administer, and provide therapeutic tests and drugs within a BON- and BOME-approved formulary. CRNPs and CNMs in collaborative practice with a physician may prescribe controlled substances in Schedules III, IV, and V pursuant to the Rules of the Alabama BOME Chapter 540-X-18. In August 2014, the BOME proposed additional rules pertaining to authorization of a Limited Purpose Schedule II

Permit for CRNPs/CNMs/PAs. Public comment closed in October 2014. CRNPs and CNMs are required to complete 12 CME credits in advanced pharmacology and prescribing trends and 4 additional credits every 2 years for renewal of the Qualified Alabama Controlled Substances Certificate under current regulation for CS III-V authority.

A BON and BOME joint committee recommends R&R governing the collaborative relationship between physicians, CRNPs, CNMs, and the prescription 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. Prescription pads must include the physician's name and address, the CRNP's or CNM's 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. CNSs and CRNAs are not regulated by the joint committee (BON and BOME) and are not eligible for prescriptive authority.

Alaska

www.commerce.alaska.gov/dnn/cbpl/ProfessionalLicensing/BoardofNursing.aspx
 www.alaskanp.org
 campaignforaction.org/state/alaska

Legal authority

APRNs are defined as an advanced nurse practitioner (ANP) and are regulated by the Alaska BON. ANPs include CNP (NP in regulation), CNM, and as of 2014, CNS roles. ANPs are further defined as RNs who, due to specialized education and experience, are certified to perform acts of medical diagnosis and prescription as well as dispense

Legislative update key

ACNP Acute Care Nurse Practitioner	CNM Certified Nurse Midwife	NA Nurse Anesthetist
ADHD Attention-Deficit Hyperactivity Disorder	CNP Certified Nurse Practitioner	NCSBN National Council of State Boards of Nursing
ANP Adult Nurse Practitioner	CNS Clinical Nurse Specialist	NPA Nurse Practice Act
APN Advanced Practice Nurse	CPA Collaborative Practice Agreement	PA Physician Assistant
APNP Advanced Practice Nurse Prescribers	CPNP Certified Pediatric Nurse Practitioner	PCNS Psychiatric Clinical Nurse Specialist
APPN Advanced Practice Professional Nurse	CRNA Certified Registered Nurse Anesthetist	PCP Primary Care Provider
APRN Advanced Practice Registered Nurse	CRNM Certified Registered Nurse Midwife	PMHNP Psychiatric Mental Health Nurse Practitioner
ARNP Advanced Registered Nurse Practitioner	CRNP Certified Registered Nurse Practitioner	PNP Pediatric Nurse Practitioner
ASTC Ambulatory Surgical Treatment Center	CS Controlled Substances	PPO Preferred Provider Organization
BC/BS Blue Cross/Blue Shield	DEA Drug Enforcement Administration	OT Occupational Therapist
BNE Board of Nurse Examiners	DO Doctor of Osteopathic Medicine	RNP Registered Nurse Practitioner
BOM Board of Medicine	DPW Department of Public Welfare	R&R Rules and Regulations
BOME Board of Medical Examiners	FNP Family Nurse Practitioner	Rx Pharmacology/Prescriptive/Prescribe.
BON Board of Nursing	GNP Geriatric Nurse Practitioner	SOP Scope of Practice
BOP Board of Pharmacy	HMO Health Maintenance Organization	WCPA Written Collaborative Practice Agreement
BRN Board of Registered Nursing	JPC Joint Practice Committee	WHNP Women's Health Nurse Practitioner
CFNP Certified Family Nurse Practitioner	LVN Licensed Vocational Nurse	
CME Continuing Medical Education	MD Medical Doctor	
CMS Centers for Medicare and Medicaid Services		

For an intermediary-carrier directory by state, visit <http://www.cms.gov/apps/contacts/>

medical, therapeutic, or corrective measures under regulations adopted by the BON. Regulations require that an ANP must have a plan for patient consultation and referral, but a physician relationship is not required. SOP for ANPs is not directly defined in statute or regulation; however, regulation refers to the national certifying body for definition of SOP in specialty areas.

ANPs in Alaska are statutorily recognized as PCPs. Nothing in the law precludes admitting privileges for ANPs. Entry into NP practice requires a graduate degree in nursing and national board certification. Continuing education (CE) requirements for ANPs are 30 CE units; 12 of these must be advanced pharmacotherapeutics and 12 hours of CE in clinical management of patients every 2 years. CRNAs practice under separate BON rules, and regulations and are not currently defined as ANPs/APRNs in Alaska.

■ Reimbursement

All healthcare in Alaska is provided on a fee-for-service basis, and 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; 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 ANPs 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 ANPs. Prescriptions are labeled with the ANP's name only. To renew prescriptive authority, ANPs and CRNAs must complete 12 contact hours of CE in advanced pharmacotherapeutics and 12 contact hours of CE in clinical management of patients every 2-year renewal cycle.

Arizona

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■ Legal authority

The Arizona State Legislature grants APRNs authority and the BON alone regulates their

practice. APRNs include RNP (inclusive of the CNP and CNM roles), CRNA, and CNS roles. According to the BON, an RNP will refer a patient to another healthcare provider if a situation or condition occurs with a patient that is beyond the RNP's knowledge and experience. No formal collaboration agreement is required. RNP SOP is defined in the Arizona Administrative Code R4-19-508.

In the SOP, RNPs are authorized to admit patients to healthcare facilities, manage the care of patients admitted, and discharge patients. However, the Arizona Department of Health regulations require that patients admitted to an acute care facility must have an attending physician. Acute care facilities apply this citation as the basis to deny independent admitting and hospital privileges to NPs. RNPs and CNSs must have a graduate degree in nursing and national board certification in their focus area to enter into practice. CRNAs must have a graduate degree associated with an accredited CRNA program and hold national certification to enter into practice.

■ Reimbursement

RNPs and other APRNs may receive third-party reimbursement, enabled by the Department of Insurance statutes. RNP reimbursement varies depending on the health insurance plan.

■ 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 area of population focus and certification. For example, women's health RNPs are not authorized to prescribe meds to males except in cases of partner therapy for sexually transmitted infections. Prescribing without documenting an assessment is 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 submit this number to the BON and the Board of Pharmacy. Drugs, other than controlled substances, may be refilled up to 1 year. CRNAs may administer anesthetics and issue medication orders for medications to be administered by a licensed, certified, or registered healthcare provider preoperatively, postoperatively, or as part of a procedure; CRNAs are not authorized to prescribe or dispense medications. CNSs do not have prescriptive authority in Arizona.

Arkansas

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campaignforaction.org/state/arkansas

■ Legal authority

The BON grants APRNs authority to practice per an additional license separate from RN licensure. APRNs include the CNP, CNM, CNS, and CRNA roles. APRNs practice independently with the exception of RNPs (NPs who do not hold national certification). In this instance, RNPs must practice under physician direction/protocol and may only transcribe orders from a protocol. The BON ceased issuing new RNP licenses in 1996. All NPs licensed after 1996 hold CNP licensure. Hospital privileges for APRNs are determined on a hospital-to-hospital basis according to the credentialing committee of each hospital. Graduate or postgraduate-level APRN education and national board certification are required for initial APRN licensure. To continue to hold an APRN license, current national certification must be maintained.

■ Reimbursement

The NPA mandates direct Medicaid reimbursement to APRNs and RNPs. Medicaid reimbursement is 80% of a physicians' rate. APNs are not recognized as PCPs for Medicaid. A statutory provision exists for third-party reimbursement for CRNAs.

■ Prescriptive authority

The NPA authorizes the BON to provide a certificate of prescriptive authority to qualified APRNs. A collaborative practice agreement with a physician of comparable specialty/scope and use of prescriptive protocols are required. APRNs with prescriptive authority may apply for and hold a DEA number. The NPA limits the prescribing of controlled substances to Schedules III-V. Neither protocols nor collaborative practice agreements with a physician are required unless the APRN has prescriptive authority.

Under the Chapter 4 Rules, an initial applicant for prescriptive authority must hold an active APRN license with completion of pharmacology course work of 3 graduate credit hours or 45 contact hours in a competency-tested pharmacology course; have 300 hours of precepted prescribing experience; and include a collaborative practice agreement with a physician. Endorsement applicants must provide prescribing evidence of at least 500 hours in the last year and have a clear DEA history. APRNs who have fulfilled requirements for prescriptive authority may receive

pharmaceutical samples and therapeutic devices appropriate to their area of practice. APRNs with prescriptive authority have implied authority to give prescriptive drug samples to patients.

California

www.rn.ca.gov

www.canpweb.org

campaignforaction.org/state/california

■ Legal authority

The California BRN grants legal authority to practice, regulate, and issue separate certification to APRNs. Defined in statute, APRN includes CNP (NP in statute), CNM, CRNA, and CNS roles. NPs function under "standardized procedures" or protocols when performing medical functions, collaboratively developed and approved by the NP, physician, and administration in the organized healthcare facility in which they work. SOP of an NP is defined within the standardized procedures, not in statute or regulation. CNPs and CNMs are statutorily recognized as "primary care providers" in California's Medi-Cal system (Medicaid). APRNs are not legally authorized to admit patients to the hospital; however, individual hospitals may grant APRNs hospital privileges. CNPs and CNSs must hold a minimum of a master's degree in nursing or health-related field to practice; however, California does not require national certification to enter into practice. CRNAs are required to hold national certification to practice in the state of California.

■ Reimbursement

All nationally board-certified CNPs are reimbursed independently by the Medi-Cal system. Medi-Cal-covered services performed by CNPs, CNMs, and CRNAs are reimbursed at 100% of the physician reimbursement rate. Blue Cross of CA Medi-Cal Provider Directory lists CNPs 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 CNMs and BRN-listed psychiatric-mental health nurses for qualifying services. Participants in the state's managed-care programs for specified Medi-Cal beneficiaries may select CNPs and CNMs as their PCPs.

■ Prescriptive authority

CNPs and CNMs may "furnish" or order drugs or devices, including controlled substances II-V when the drugs or devices are furnished by a CNP or CNM in accordance with a standardized procedure and when separate authorization is granted by

the BRN. The act of "furnishing" requires physician supervision of the CNP and CNM; however, physical presence of the physician is not required. The act of "furnishing" is legally the same as the act of prescribing. Prescriptions are labeled with the CNP's or CNM's name only. CNPs and CNMs may request, receive, and dispense pharmaceutical samples and may dispense drugs, including controlled substances. CNSs and CRNAs do not have prescriptive authority in California.

Colorado

www.dora.colorado.gov/professions/nursing

www.nurses-co.org

campaignforaction.org/state/colorado

■ Legal authority

The State BON grants advanced practice authority to RNs who meet the criteria set forth in the Colorado NPA and the Board R&Rs for inclusion on the Advanced Practice Registry (APR), regulates the practice of APRNs, and affords title protection. APRNs are defined as "APN" in the State of Colorado and include the CNP (NP in statute), CNS, CNM, and CRNA roles. APNs are deemed to be independent practitioners. National certification in a role and population focus is required of all APR applicants. APNs listed on the registry prior to July 1, 2010 may retain their listing on the APR without certification so long as the APN does not allow their advanced practice authority to lapse or expire.

APNs engaged in an independent practice must be covered by professional liability insurance. The scope of advanced practice nursing is based on the professional nurse's SOP within the APN role and population focus, which may include, but is not limited to, performing acts of advanced assessment, diagnosing, treating, prescribing, ordering, selecting, administering, and dispensing diagnostic and therapeutic measures. Prescribing medication is not within the APN's SOP unless the APN has applied for and been granted prescriptive authority by the Board. The NPA and Board rules do not address and, therefore, do not prohibit, APNs from being designated as PCPs or being granted hospital privileges; however, APNs are not currently recognized as PCPs in statutes and regulations under the jurisdiction of state agencies regulating healthcare.

■ Reimbursement

Medicaid reimburses APN services; however, some managed-care Medicaid companies restrict independent APNs from joining networks. Third-party reimbursement is available to APNs, but third-party payers are

not mandated to credential, empanel, or reimburse APNs.

■ Prescriptive authority

Those Colorado APNs granted prescriptive authority by the board enjoy full prescriptive authority within their board-recognized role and population focus, including Schedule II-V controlled substances when the APN with prescriptive authority holds a valid DEA registration. Additional requirements include national certification in the role and population focus of the APN, professional liability insurance as required by board rules, and additional experiential and safe prescribing requirements, including preceptorship, mentorship, and an articulated plan for full prescriptive authority. Following completion of the mentorship, a one-time physician signature is required to attest to the existence of an articulated plan. The attestation form is kept on a file at the BON. The APN is responsible for reviewing his or her articulated plan on a yearly basis, and articulated plans may be audited by the BON. Board rules authorize APNs with prescriptive authority to receive and distribute a therapeutic regimen of prepackaged and labeled drugs, including free samples.

Connecticut

www.ct.gov/dph/cwp/view.asp?a=3143&q=388910

www.ctaprn.org

www.campaignforaction.org/state/Connecticut

■ Legal authority

APRNs are defined in the NPA, regulated by the Connecticut State Board of Examiners for Nursing, and include the CNP (NP in statute), CNS, and CRNA roles. With the passage of Public Act No. 14-12 in 2014, CT APRNs gained full practice authority following not less than 3 years and for not less than 2,000 hours of APRN practice in collaboration with a physician. Independent practice and collaborative practice are defined by the BON. SOP for APRNs is defined in statute. The NPA specifically authorizes RNs to operate under an order issued by an APRN. APRNs are statutorily recognized as "PCPs" and are authorized to admit patients and hold hospital privileges. A graduate degree in nursing or other related field and national board certification are required to enter into practice. CNM authority is regulated by the Department of Public Health, and SOP is recognized under a separate statute (Chapter 377, Midwifery).

■ Reimbursement

Medicaid regulations govern reimbursement to APRNs under the remaining Medicaid fee-for-service programs. NPs, psychiatric

CNSs (PCNSs), and CNMs are reimbursed for services under state insurance statutes, which affect only private insurers. Reimbursable services must be within the individual's SOP 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

Following the passage of Public Act No. 14-12 in 2014, APRNs may independently prescribe, dispense, and administer medications autonomously, including Schedules II-V controlled substances following not less than 3 years and not less than a 2,000-hour transition to practice period. APRNs and CNMs are legally authorized to request, receive, and dispense pharmaceutical samples.

Delaware

dpr.delaware.gov/boards/nursing/index.shtml
denurses.org

campaignforaction.org/state/delaware

■ Legal authority

APRNs are defined as an APN and are regulated by the Delaware BON. APNs include CNP, CNS, CNM, and CRNA roles. Practice authority is governed solely by the BON if the APN's SOP does not include independent acts of diagnosis or prescribing. If the APN wishes to provide independent acts of diagnosis or prescribing, the APN must apply to the JPC (composed of APNs, MDs, a pharmacist, and one public member). The JPC is statutorily empowered, with Board of Medical Licensure and Discipline (BMLD) 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 outlining 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. In addition, 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 healthcare delivery system." If the agreement is with a licensed healthcare delivery system, the document must clarify that the system will supply

appropriate medical backup for the purposes of consultation and referral. APN applicants must have a master's degree or postbasic certificate in a clinical nursing specialty, be nationally certified, submit a copy of their collaborative agreement, and show evidence of BON-specified relevant courses. If the APN has graduated from an approved program more than 2 years before application, the APN must document the equivalent of at least 30 CE hours in pharmacology and other areas.

■ Reimbursement

Delaware has statutory provisions requiring health insurers, health service corporations, and health maintenance organizations (HMOs) to provide benefits for eligible services when rendered by an APN acting within his or her SOP. APNs may be listed on provider panels, and some providers are recognizing APNs on managed-care provider panels. CNMs have legislative authority under the Board of Health for third-party reimbursement. FNP's and PNP's also receive Medicaid reimbursement at 100% of the physician payment.

■ Prescriptive authority

JPC- and BMLD-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 both the State Controlled Substance Agency and the DEA. 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, prescriber's ID and DEA numbers, and signature (when applicable).

District of Columbia

doh.dc.gov/service/board-nursing
www.npadc.org

campaignforaction.org/state/district-columbia

■ Legal authority

The Washington, D.C. Department of Health BON approves and regulates APRNs. APRNs include the CNP role (NP title in D.C.), the CNS role, the CNM role, and the CRNA role. Current law authorizes APRNs to practice independently without a physician collaborative agreement or protocols. APRN SOP is defined in statute, regulated by the BON, and without limitations. APRNs may apply for

admitting privileges to the hospital. National certification in a specialty area is required to enter into practice.

■ Reimbursement

APRNs receive direct reimbursement for providing drug abuse, alcohol abuse, and mental illness care; healthcare plans or institutions are prohibited from discriminating against APRNs with clinical privileges. Legislative authority mandating APRN reimbursement does not exist; however, private third-party payers reimburse for NP services. APRNs 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 law and R&R authorize prescribing Schedules II-V controlled substances and allow dispensing of all medications, including sample medication. APRNs are authorized to request and receive pharmaceutical samples. The D.C. Pharmacy Board issues a Controlled Substance Registration to providers with controlled substance authority. Prescriptions are labeled with the APRN's name.

Florida

www.floridasnursing.gov
www.floridanurse.org
campaignforaction.org/state/florida

■ Legal authority

APRNs are defined as Advanced Registered Nurse Practitioners (ARNPs) and include CNP (NP in statute), CNM, and CRNA roles. The CNS role is defined in statute; however, CNSs do not have advanced practice authority. The BON certifies and regulates ARNPs and CNSs. APRN SOP is defined in statute and includes the performance of medical acts of diagnosis, treatment, and operation pursuant to protocols established between the ARNP, MD, DO, or dentist. Within the framework of established protocols, ARNPs may order diagnostic tests, physical therapy, and occupational therapy. The degree and method of supervision, determined by the ARNP and MD, DO, or dentist, is specifically identified in written protocols and shall be appropriate for prudent healthcare providers under similar circumstances.

ARNPs must file protocols with the BON when renewing their licenses, and when there are changes to the protocol, the physicians working with the ARNP must send the statement required in the medical practice act to the BOM. BOM and BON rules define general supervision as the ability to

communicate/contact by telephone; the supervising practitioner's on-site presence is not required. ARNPs are authorized to admit patients to the hospital and hold hospital privileges; however, this authority is dependent upon privileges granted by the institution and the supervising physician. ARNP applicants must have a master's degree to qualify for initial certification and are required to hold national board certification to enter practice. CNSs must hold a master's degree in a clinical nursing specialty and either national certification in a CNS specialty or proof of having completed clinical experience in a CNS specialty for which there is no available national certification.

■ Reimbursement

ARNPs receive Medicaid, Medicare, Champus, 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 ARNPs at 85% of the physician rate if the physician is not on-site and does not countersign. In 2008, Florida initiated a pilot program for Medicaid-managed care. Providers must be on approved panels. Managed-care companies are prohibited from discriminating against the reimbursement of ARNPs if based on licensure. Private insurers must reimburse CNM services if the policy includes pregnancy care.

■ Prescriptive authority

The BON/BOM joint committee allows prescriptive privileges for ARNPs; however, independent prescribing of controlled substances is excluded. ARNPs prescribe under a 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, or dispense pharmaceutical samples. CNSs do not have prescriptive authority in Florida.

Georgia

sos.ga.gov/index.php/licensing/plb/45
campaignforaction.org/state/Georgia
uaprn.enpnetwork.com/
www.georgianurses.org/

■ Legal authority

ARNPs are defined in statute and include the CNP (NP in statute), CNM, CRNA, and

CNS roles (all CNSs as of January 1, 2012 meeting education and national certification criteria). A master's degree or higher in nursing or other related field and national board certification are required for all APRNs at entry into practice (except for CRNAs educated prior to 1999). APRN's authority to practice is granted through one of two statutes: OCGA 43-34-25 and OCGA 43-34-23. APRNs authorized to practice under 43-34-23 are regulated by the BON. 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 through a "nurse protocol." A "nurse protocol" is defined as a written document signed by the NP and physician in whom the physician delegates authority to the nurse to perform certain medical acts and provides for immediate consultation with the delegating physician. The issuance of a written prescription is prohibited.

APRNs practicing under OCGA 43-34-25 have prescriptive authority. There is joint regulation by the BON and BOM in that APRN's requesting prescriptive authority are required to submit, under BOM rules, a Nurse Protocol Agreement that must be approved by the Board of Medicine. Practice under 43-34-25 prohibits APRNs from ordering certain radiographic imaging tests, such as MRIs and CT scans, unless there are "life-threatening situations." There is a universal requirement for periodic review of a sampling of patient records as well as a requirement for patient evaluation and exam by the delegating physician in certain circumstances. Practice is delegated supervisory in nature. APRNs may hold hospital privileges in certain situations.

■ Reimbursement

There are no statutes mandating the third-party reimbursement for APRNs. FNPs, PNs, 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 100% of a physician's payment. Some private insurers reimburse APRNs but are not required by law to do so.

■ Prescriptive authority

APRNs practicing under a nurse protocol as defined by OCGA 43-34-23 defines a process that permits RNs (including APRNs) to administer, order, or dispense drugs under delegated medical authority as either prescribed by a physician or authorized by protocol. APRNs practicing under a nurse

protocol agreement defined and approved by the BOM as authorized by OCGA 43-34-25 may issue a written drug order, including the authority to prescribe CS III-V, and request, receive, sign for, and distribute pharmaceutical samples. 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.

Hawaii

hawaii.gov/dcca/pvl/boards/nursing
hapnurses.org
campaignforaction.org/state/hawaii

■ Legal authority

The BON licenses and regulates APRNs in Hawaii consistent with the National Council of State Boards of Nursing APRN Consensus Model. APRNs include the CNP (NP in regulation), CNS, CNM, and CRNA roles and have independent SOP and prescriptive authority. APRN SOP is defined in statute and regulation and conforms to the NCSBN Model Nurse Practice Act for APRNs. Recent legislation passed enabling hospitals licensed in Hawaii to recognize APRNs, allow them to function with full SOP, and to act as a PCP in their institutions. The minimum requirements to enter practice in Hawaii include completion of an accredited, graduate-level education program preparing the nurse for one of the four recognized APRN roles and national certification in the APRN's clinical specialty.

■ Reimbursement

Current law provides direct reimbursement to all APRNs and authorizes all insurers to legally recognize APRNs as PCPs. The reimbursement rate ranges from 85% to 100%. NPs and CNSs are also reimbursed through CHAMPUS. Medicaid expanded the types of APRNs they reimburse to include PCNSs and additional NP specialties. Medicaid reimburses at 75% of the physician payment. Hawaii Health QUEST, a Medicaid waiver program, defines PNs, FNPs, and CNMs as PCPs.

■ Prescriptive authority

The BON regulates APRN prescriptive authority, and APRNs have legal authority to prescribe medications, including Schedules II-V controlled substances, independently. APRNs with prescriptive authority are legally authorized to request, receive, and dispense manufacturer's prepackaged pharmaceutical samples. APRNs may not request, receive, or sign for controlled substance samples; however, they may prescribe, order, and dispense medical devices and equipment.

APRN prescribers' prescriptions are labeled with the APRN's name.

Idaho

ibn.idaho.gov/IBNPortal
www.npidaho.org
campaignforaction.org/state/idaho

■ Legal authority

The BON regulates and grants full practice authority to APRNs. APRNs include the CNP, CNS, CNM, and CRNA roles. APRN licensure requires RN licensure, completion of an approved APRN program, and national certification. NPA rules rely on the Decision-Making Model to determine an APRN's SOP. The APRN can determine if a specific function can be legally performed by determining the following: if the act is expressly forbidden in the NPA Rules and Regulations, was taught in the APRN curriculum, acquired through additional education, whether the APRN is clinically competent to perform it, does not exceed employment policies, is consistent with national specialty organization standards, and is within the accepted standard of care for the APRN's geographic region and practice setting.

APRNs are not statutorily recognized as PCPs; however, Idaho has an "any willing provider" language in statute. APRNs are legally authorized to admit patients to hospitals and hold hospital privileges in Idaho. Some facilities have granted APRNs privileges. State law requires a minimum of a graduate/postgraduate degree as entry into practice; however, APRNs educated prior to January 1, 2016 are exempt from the requirement for a graduate/postgraduate degree; the NPA has previously required national board certification to enter practice, which requires a master's degree in nursing to enter into most specialties.

■ Reimbursement

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

■ Prescriptive authority

Prescriptive and dispensing authority is granted to APRNs who have completed 30 contact hours of pharmacology-specific formal instruction beyond basic RN education. Authorized APRNs may prescribe and dispense legend and Schedules II to V

controlled substances appropriate to their defined SOP. Authorized APRNs have their own DEA numbers and prescribe independently. APRNs are legally authorized to request, receive, and dispense pharmaceutical samples, and APRN prescriptions are labeled with the APRN's name only.

Illinois

www.idfpr.com/dpr/WHO/nurs.asp
www.isapn.org
campaignforaction.org/state/illinois

■ Legal authority

APRNs are defined as APNs in the State of Illinois and include the CNP, CNS, CRNA, and CNM roles. The Illinois Department of Financial and Professional Regulation (IDFPR) grants authority and regulates the practice of APNs. APNs must have a written collaborative agreement with a physician, podiatrist, or dentist, except for APNs who are credentialed and privileged in a hospital or ambulatory surgical treatment center (ASTC). Collaboration is defined in Section 65-35 (b and c) between an APN and a collaborating physician, podiatrist, or dentist (CRNAs only) and is considered adequate if the collaborating physician or podiatrist provides collaboration and consultation with the APN at least once a month.

APNs may provide services within a hospital or ASTC if clinical privileges have been granted by the facility. New APN applicants must have a graduate degree or a postmaster's certificate from a graduate-level program appropriate for national certification in a clinical advanced practice nursing specialty. Additionally, the APN must hold current RN licensure and national certification as a CNP, CNS, CNM, or CRNA from the appropriate national certifying body as determined by rule of IDFPR. There is an exception to the graduate degree requirement for CRNAs who completed their CRNA program prior to January 1, 1999 and have kept their certification up-to-date. This exception will expire on June 30, 2018.

■ Reimbursement

The Illinois Department of Public Aid provides direct reimbursement at 100% of the physician rates to all APN roles who enroll as Medicaid providers. Medicaid recipients in more populated counties are being transitioned to managed-care organizations (MCOs). Each MCO has its own policies regarding its provider network, which commonly involves contracting with health systems—not individual providers. Some Medicaid recipients will remain on the traditional fee-for-service program,

Illinois Health Connect (IHC). APNs who wish to be included on primary care panels with IHC must obtain additional approval from the IHC medical director. This approval has been successfully obtained by several CNPs in Illinois. It is also possible for an office to bill for the services of APNs under a physician's provider number and receive 100% reimbursement for those services. Statutory prohibition for third-party reimbursement to APNs does not exist. APNs receive direct or indirect reimbursement from some third-party payers.

■ Prescriptive authority

Prescriptive authority is delegated by a physician, podiatrist, or dentist as a part of the written collaborative agreement or clinical privileges in a hospital or ASTC. If so noted in the collaborative agreement, an APN may prescribe Schedules III-V controlled substances without restrictions and also may prescribe oral, transdermal, or topical Schedule II medications (225 ILCS 65/65-40). Injectable Schedule II medications may not be delegated. The collaborative agreement may authorize dispensing of medications. APNs who work without a written collaborative agreement by virtue of being credentialed and privileged by a hospital or ASTC may complete discharge prescriptions provided the prescription is in the name of the APN and the attending or discharging physician (225 ILCS 65/65-45).

Indiana

www.in.gov/pla/nursing.htm
www.indiananurses.org
campaignforaction.org/state/indiana

■ Legal authority

APRNs are defined as APNs in the State of Indiana and include CNP (NP in regulation), CNM, CNS, and CRNA roles. The Indiana State BON grants the authority to and regulates APNs. The BON does not issue additional, separate licenses or certification to NPs or CNSs; however, CNMs must apply for "limited licensure" to practice. 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. SOP is defined in regulation. National certification is required to obtain prescriptive authority if the APN holds a baccalaureate degree. APNs with a graduate degree do not need to be nationally certified for prescriptive authority to be granted. CNSs are required to hold a minimum of a master's degree to practice.

■ 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 the following: the manner in which the APN and licensed physician will cooperate, coordinate, and consult with each other in the provision of healthcare and 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 ID 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.

Iowa

www.state.ia.us/nursing
www.iowanurses.org
campaignforaction.org/state/iowa

■ Legal authority

APRNs are defined as ARNP in the state of Iowa and include the CNP, CNS, CNM, and CRNA roles. The BON grants ARNPs authority to practice and regulates their practice through administrative rules. ARNPs

are authorized to practice independently within their recognized nursing specialties, and collaborative practice agreements are not required by the BON. SOP is broadly defined. ARNPs are statutorily recognized as PCPs; however, state law does not contain “any willing provider” language. ARNPs may hold hospital clinical privileges. Registration as an ARNP requires current licensure as an RN and certification by a national certifying body. A master’s degree in nursing is only required for CNSs.

■ Reimbursement

Iowa’s Medicaid managed-care and prepaid-service programs reimburse ARNPs. Payment of necessary medical or surgical care, and treatment is provided to an ARNP in third-party reimbursement if the policy or contract would pay for the care and treatment when provided by a physician or DO. MCOs are not mandated to offer ARNP coverage unless there is a contract or other agreement to provide the service. All ARNPs are approved as providers of healthcare services pursuant to managed-care or prepaid-service contracts under the medical assistance program.

■ Prescriptive authority

Authorized ARNPs are granted full, independent Rx authority within their nursing specialty, including Schedules II-V controlled substance medications. ARNPs may prescribe, deliver, distribute, or dispense noncontrolled and controlled drugs, devices, and medical gases, including pharmaceutical samples. ARNPs must register with the DEA, and prescriptions written by ARNPs must be labeled with their name.

Kansas

www.ksbn.org
www.kcnpnm.org
campaignforaction.org/state/kansas

■ Legal authority

The Kansas BON grants authority to APRNs and regulates the practice, issuing a separate license. Recognized APRN roles include the CNP (NP in regulation), CNS, CNM (NM in regulation), and CRNA (RNA in statute). APRNs function in collaborative relationships with physicians and other healthcare professionals in the delivery of primary healthcare services. APRNs make independent decisions about the nursing needs of patients and interdependent decisions with physicians in carrying out health regimens for patients; however, the physical presence of a physician is not required when care is given by the APRN. Any APRN who

interdependently develops and manages the medical plan of care for patients or clients is required to have a signed authorization for collaborative practice with a physician who is licensed in Kansas (60-11-010 [b]).

Each authorization for collaborative practice shall include a cover page containing the names and telephone numbers of the APRN and the physician, their signatures, and the date of review by the ARNP and the physician. Each authorization for collaborative practice shall be maintained in either hard copy or electronic format at the APRN’s principal place of practice. SOP is defined in statute and regulation; however, APRNs are not recognized as “PCPs.” No specific language in statute authorizes or prohibits hospital privileges; admitting and hospital privileges are determined by individual institution policy and procedure. APRN applicants in all categories require a master’s degree or higher in nursing, and national board certification is not required to enter practice in Kansas, except for RNAs.

■ Reimbursement

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

■ Prescriptive authority

APRNs, with the exception of CRNAs, are legally authorized to prescribe medications, including Schedules II-V controlled substances pursuant to a collaborative practice agreement and written protocol that contains a precise and detailed medical plan of care for each classification of disease or injury for which the APRN is authorized to prescribe and shall specify all drugs, which may be prescribed by the APRN. These can be published protocols or practice guidelines that have been agreed upon by both the APRN and physician. The prescription order must be signed by the APRN and include the name of the physician and APRN. The APRN must register with the DEA and the BON if they prescribe controlled substances. Prescription labels include both the APRN’s and physician’s name. APRNs are authorized to request, receive, and distribute pharmaceutical samples—with the exception of

controlled substances—if the drug is within their protocol.

Kentucky

kbn.ky.gov

www.kcnpnm.org

campaignforaction.org/state/kentucky

■ Legal authority

The Kentucky BON grants APRNs authority to practice and regulates their practice. APRNs are statutorily defined as CNPs, CNSs, CNMs, and CRNAs. APRNs must have a collaborative agreement for prescriptive authority with a physician; this agreement only applies to the act of prescribing (see Prescriptive Authority update below). APRNs may practice autonomously within their relative SOPs; however, they must practice in accordance with the SOP of the national certifying organization as adopted by the BON in regulation. CNP SOP is defined in Kentucky statute, KRS 314.011: “APRNs shall seek consultation or referral in situations outside their SOP.” APRNs are recognized as “PCPs” in regulation, 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, doctorate, or postmaster’s certificate as an APRN and national board certification are required to enter practice in Kentucky.

■ Reimbursement

The state medical assistance program reimburses APRNs for services at 75% of the physician rates in all state regions except Jefferson County. In the Jefferson County region, there is capitated managed care through a healthcare partnership with reimbursement at physician rates. Kentucky is an “any willing provider” state. In April 2003, the U.S. Supreme Court upheld the Kentucky law providing that a health insurer may not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer.

■ Prescriptive authority

APRNs may prescribe Schedules II-V controlled substances and nonscheduled legend drugs pursuant to separate “Collaborative Agreement for Prescriptive Authority for Nonscheduled Drugs (CAPA-NS)” and “Collaborative Agreement for Prescriptive Authority for Controlled Substances (CAPA-CS).” The CAPA-CS and NS define APRN’s scope of prescribing authority and are signed by the APRN and

the physician. The passage of SB 7 (Hornback) in 2014 removes the CAPA-NS requirement following 4 years of prescribing experience under a CAPA-NS; a CAPA-CS is required if prescribing controlled substances.

APRNs may prescribe scheduled medications with the following limitations: CS II controlled substances for a 72-hour supply with additional authority for psychiatric/mental health clinicians; Schedule III controlled substances may be prescribed for a 30-day supply without refills; Schedules IV and V controlled substances may be prescribed with refills not to exceed a 6-month supply with the following limitations: diazepam, clonazepam, lorazepam, alprazolam, and carisoprodol may be prescribed for 30 days without refills. CRNAs do not need CAPAs to deliver anesthesia care. The APRN alone signs his or her name to the prescription pad when prescribing. APRNs must complete 5 contact Rx hours annually as part of their CE requirement (as of 2012, all APRNs with a CAPA-CS must include 1.5 of the 5 contact hours related to the use of the prescription monitoring system [KASPER], pain management, or addiction disorders). APRNs are legally authorized to request and receive as well as dispense noncontrolled legend pharmaceutical samples. Dispensing is applicable to APRNs working in health departments: APRNs may dispense with a written agreement with a local pharmacist.

Louisiana

www.lsnb.state.la.us

www.lanp.org

campaignforaction.org/state/louisiana

■ Legal authority

APRNs are licensed by the BON and include the CNP (NP in statute), CNM, CRNA, and CNS roles. 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 that are mutually agreed upon by the APRN, physician(s), or dentist(s), including consultation or referral availability, clinical practice guidelines, and patient coverage.

APRNs’ SOP is addressed in regulation in that “patient services provided by an APRN must be in accord with the educational preparation of that APRN.” The APRN SOP includes the following: 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. APRNs may not receive samples of controlled substances. Louisiana State law includes “Any Willing Provider” language, and APRNs are legally authorized to hold hospital privileges. 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

Prior legislation prohibits qualified plans from excluding direct reimbursement of healthcare services provided by an APRN. Medicaid recognizes NPs, CNSs, and CNMs as PCPs and will recognize those APRNs as the PCP or “Medical Home” under certain circumstances. APRNs are reimbursed at 80% of the physician fees per Medicaid; some immunizations and certain screening services for children are reimbursed at 100%. All billing must be under the APRN’s provider number, essentially eliminating “incident to” billing, though that option is available under certain conditions.

■ 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 legend and controlled drugs. 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 is served by the collaborative practice.

Maine

www.state.me.us/boardofnursing

www.mnpa.us

campaignforaction.org/state/maine

■ Legal authority

The Maine BON authorizes and regulates APRN practice. APRNs licensed by the BON are defined as CNPs, CNMs, CNSs, and CRNAs. CNSs practice in an independent role; however, a CNP who qualifies as an APRN must practice for at least 24 months under the supervision of a licensed physician, NP, 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. Following

this period, the CNP practices independently. CRNAs are responsible and accountable to a physician or dentist.

The APRN SOP, 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." Psychiatric and Mental Health CNPs and certified PCNSs may sign documents for emergency involuntary commitment through EDs. APRNs are statutorily defined as "PCPs" 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. Current law requires a master's degree in nursing and national certification to enter into practice.

■ Reimbursement

The 1999 Act to Increase Access to Primary Health Care Services (HP617) 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 ID numbers to CNPs and CNMs; and allows managed-care enrollees to designate CNPs as their PCP. However, MCOs 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 in full, on a fee-for-service basis, for services provided by certified family NPs, CPNPs, and CNMs.

■ Prescriptive authority

CNPs and CNMs may prescribe and dispense drugs or devices, including Schedule II-V controlled substances, 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 and CNMs may prescribe Schedule II-V controlled substances and drugs off-label, according to common and established standards of practice. In the 2014 legislative session, CNPs were granted authority to certify patients to receive therapeutic or palliative benefit from medical use of marijuana. CNPs and CNMs may receive and distribute drug

samples included in the formulary for Rx writing.

Maryland

www.mbon.org

www.npamonline.org

campaignforaction.org/state/maryland

■ Legal authority

The Maryland Board of Nursing regulates APRN practice. APRNs include the CNP (CRNP in statute), CRNA, CNM, and CNS roles. Maryland also recognizes nurse psychotherapists as APRNs (APRN/PMH). SOP for NPs is independent, is defined in statute and regulations, and is in accordance with the Standards of Practice of the American Association of Nurse Practitioners or any other national certifying body recognized by the board; CNPs must submit a board-approved written attestation confirming the CNP has a collaboration agreement with a physician. Scope and standards of independent practice for NPs are defined in statute and regulations. CRNAs practice in collaboration with an anesthesiologist, physician, or dentist and as of 2014, CNMs practice independently without a collaborative practice agreement. The minimum degree required to enter practice in the State of Maryland is a master's degree in addition to national board certification.

■ Reimbursement

All nurses are entitled to private third-party and Medicaid reimbursement for services if they are practicing within their legal SOP. All Medicaid recipients have been assigned to an MCO; CNPs (with the exception of neonatal and acute care) and CNMs have been designated as PCPs and may apply to be placed on a provider panel. Medicaid reimburses at 100% of physician payment. Legislation allows due process for APNs listed on managed-care panels; APRNs are not to be arbitrarily denied. The law does not require, however, that an HMO include CNPs on the HMO panel as PCPs. Several commercial insurers reimburse NPs directly, however, at a rate of 75% to 85% of a physician's fee schedule.

■ Prescriptive authority

CNPs and CNMs have full prescriptive authority, including Schedule II-V controlled substances. The scope of prescriptive authority is defined in statute. NPs and CNMs are authorized to obtain both federal and state DEA numbers. NPs are legally authorized to dispense medications in public health settings and student health clinics. Prescription containers are labeled with the NP or CNM name.

Massachusetts

www.mass.gov/dph/boards/rn

www.mcnpweb.org

campaignforaction.org/state/Massachusetts

■ Legal authority

The Massachusetts BON grants APRNs the authority to practice and regulates their practice. APRNs include the CNP, CRNA, PCNSs, and CNM roles. With the exception of CNMs who no longer require written guidelines or a supervising physician, APRNs eligible for prescriptive practice must establish 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 for prescriptive practice as is customarily accepted in the specialty area.

Advanced practice R&Rs governing the ordering of tests, therapeutics, and prescribing are promulgated by the BON with concurrence from the BOM; all other areas of SOP are exclusively under the BON. SOP is defined both in statute and regulation. Massachusetts recognizes APRNs as PCPs; however, state law does not contain "any willing provider" language. Credentialing for hospital privileges varies according to hospital policies. For initial (not reciprocal) APRN authorization, Massachusetts mandates a minimum of a graduate degree. National certification is required to enter into practice.

■ Reimbursement

FNPs, PNPs, and adult NPs are reimbursed at 100% of the 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, NMs, and NAs in accordance with Chapter 302 of the Acts and Resolves of 1994. These include indemnity plans, nonprofit hospital corporations, medical service corporations, and HMOs. BC/BS, Fallon, and Neighborhood Health Plan credential NPs in private practice settings to receive individual provider numbers. Effective January 2009, all health insurers are required to recognize NPs as PCPs and include them in provider directories for consumer choice.

■ Prescriptive authority

Massachusetts state law provides for prescriptive authority for CNPs, CNMs, CRNAs, and PCNSs, including Schedule II controlled substances. Authorized APRNs must apply to the Massachusetts Department of Public Health for state registration and then apply for a federal DEA number. With the exception of CNMs who no longer require written guidelines or a supervising physician, authorized APRNs have guidelines for

prescriptive practice mutually developed and agreed on by the nurse and supervising physician that include a defined mechanism to monitor prescribing practices. Initial prescription of Schedule II drugs requires review within 96 hours. Authorized APRNs are allowed to request, receive, and dispense pharmaceutical samples. The prescription pad includes the name of the supervising physician and the APRN; however, the authorized APRN signs the prescription.

Michigan

www.minurses.org

www.micnp.org

campaignforaction.org/state/michigan

■ Legal authority

The BON authorizes advanced practice authority as a specialty certification; however, Michigan is one of the few states without an NPA or a definition of APRNs in statute. Nurse specialists are defined by the board as NPs, NMs, and NAs. According to the Michigan Council of Nurse Practitioners (although no statute exists requiring supervision or collaboration to practice with the exception of prescriptive authority), the state has recently interpreted NP practice as “supervised” due to their ability to “diagnose,” which is defined as the practice of medicine. Clarification by the BON, “The advanced practice nurses are authorized to practice through the certification issued to them as a registered nurse.

The certification recognizes the additional training and completion of a certification program that enables the registered nurse to handle tasks of a more specialized nature that are delegated to him or her...without the benefit of a defined scope of practice, we are left with the scope indicated for a registered nurse and what tasks can be delegated by another licensee, which is typically a physician.” Under some HMOs and systems, NPs are recognized as “PCPs.” 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, this is dependent on the institution, and 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. CRNAs and CNMs are also recognized by Medicaid and directly reimbursed. 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, NAs, and NMs may prescribe noncontrolled substances as a delegated act of a physician. There is no requirement for a physician’s countersignature. Under BOM administrative rules, a physician may delegate prescriptive authority for Schedules III-V controlled substances to NPs and NMs if “the delegating physician establishes a written authorization,” containing names and license numbers of the physician, NP, or NM, and the limitations or exceptions to the delegation. Written authorizations must be reviewed annually.

The DEA requires NPs and NMs to obtain DEA numbers for those prescribing controlled substances. Schedule II controlled substances may also be delegated if the physician, NP, or NM is 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 have the name of the physician.

Minnesota

www.nursingboard.state.mn.us

www.mnnp.org

www.mnaprnc.org

campaignforaction.org/state/minnesota

■ Legal authority

The Minnesota Board of Nursing grants APRNs the authority to practice and regulates their practice. APRNs include the CNP, CNS, CNM, and CRNA roles. Effective January 2015, APRNs have independent practice in Minnesota. CNPs and CNSs are required to complete a “postgraduate practice” period of at least 2,080 hours within the context of a collaborative agreement with a physician or APRN prior to independent practice and prescriptive authority. CRNAs and CNMs do not have a postgraduate practice requirement. SOP for APRNs is defined in statute, and they are legally recognized as PCPs as defined under this new law. APRNs are legally authorized to admit patients to hospitals and hold hospital privileges as defined within their SOP. Minnesota APRNs are licensed by the BON following completion of an accredited

graduate-level APRN program and national certification by a recognized APRN certifying organization.

■ Reimbursement

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

■ Prescriptive authority

Beginning January 2015, APRNs may prescribe, receive, dispense, and administer drugs, including Schedules II-V controlled substances independently. CRNAs must hold a written prescribing agreement with a physician when providing nonsurgical pain therapies for chronic pain symptoms. APRNs must register with the DEA, and they have statutory authority to request, receive, and dispense sample medications.

Mississippi

www.msbn.state.ms.us

www.msurses.org

campaignforaction.org/state/mississippi

■ Legal authority

The Mississippi BON grants APRNs the authority to practice and regulates their practice. APRNs include the CNP, CNS, CNM, and CRNA roles. CNPs, CRNAs, and CNMs practice in a collaborative relationship with physicians in Mississippi. The collaborating physicians’ practice must be compatible with the CNP’s practice. APRNs must practice according to a BON-approved protocol agreed on by the APRN and physician. Practicing in a site not approved by the BON, with a physician not approved by the BON, or according to a protocol not approved by the BON, is in violation of the NPA R&Rs. SOP is defined and regulated by the BON. CNPs are statutorily recognized as PCPs; however, Mississippi law does not contain “any willing provider” language. APRNs are legally authorized to admit patients and hold hospital privileges. APRNs are required to have a master’s degree or higher in nursing, nurse anesthesia, or midwifery and must be nationally certified to enter into practice.

■ Reimbursement

Medicaid reimbursement is available to APRNs at 90% of the physician payment. Insurance law specifies that whenever an insurance policy, medical service plan, or hospital service contract provides for

reimbursement for any service within the SOP of an CNP working under the supervision of a physician, the insured shall be entitled to reimbursement whether the services are performed by the physician or NP. Reimbursement is increased to 100% for CNPs who provide healthcare services after 5 p.m.

■ Prescriptive authority

CNPs and CNMs have full prescriptive authority, including Schedules II-V controlled substances, based on the standards and guidelines of the CNP or CNM's national certification organization and a BON-approved protocol that has been mutually agreed on by the CNP or CNM and qualified physician. The protocol must outline diagnostic/therapeutic procedures and categories of pharmaceutical agents that may be ordered, administered, dispensed, and/or prescribed for patients with diagnoses identified by the CNP. CNPs may receive and distribute prepackaged medications or samples of noncontrolled substances for which the NP has Rx authority. Controlled substances (II-V) may be prescribed pursuant to additional BON rules and regulations: the NP must have a DEA number, completed a BON-approved educational program, and submittal of 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.

Missouri

pr.mo.gov/nursing.asp
www.missourinurses.org
campaignforaction.org/state/Missouri

■ Legal authority

The Missouri BON grants APRNs the authority to practice and regulates their practice. APRNs include the CNP, CNS, CNM, and CRNA roles. APRNs practice in collaboration with physicians in Missouri. Collaborative practice includes written agreements, written protocols, or written standing orders. R&Rs define the Collaborative Practice (CP) Rule. Three focus areas in the CP rule include geographic areas to be covered, methods of treatment that may be covered by CP arrangements, and requirements for review of services provided pursuant to a CP arrangement. A written CP arrangement with a physician is not needed when the APRN is performing nursing acts consistent with the APRN's 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 APRN's skill, training, education, and competence. CRNAs practice under the direction of the surgeon, anesthesiologist, dentist, or podiatrist. Individuals are recognized by their specific clinical nursing specialty area as a CNP, CNS, CNM, or CRNA, which delineates their title and SOP as APRNs in R&Rs. When practicing outside their recognized clinical nursing specialty, individuals must practice and title as RNs only. Missouri law does not recognize APRNs as PCPs and does not contain "any willing provider" language. Additionally, APRNs are not legally authorized to admit patients or hold hospital privileges. NPs are required to hold a graduate degree in nursing and national certification to enter into practice in Missouri.

■ Reimbursement

Current law states "Any health insurer, nonprofit health service plan, or HMO shall reimburse a claim for services provided by an APRN, if such services are within the SOP of such a nurse." Medicaid reimbursement is made to APRNs enrolled as Missouri Medicaid fee-for-service providers and Medicaid-enrolled APRNs associated with a federally qualified healthcare or rural healthcare facility or both. 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/clinical services furnished to the extent permitted 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 CNPs, CNSs, and CNMs includes prescription drugs and devices and Schedules III-V controlled substances as delegated by a physician pursuant to a written CP arrangement. CNPs, CNSs, and CNMs must complete 1,000 hours of postgraduate clinical experience in the APRN role prior to application for CS authority. CRNAs have prescriptive authority but are prohibited from prescribing controlled substances. Schedule III prescriptions will be limited to a 120-hour supply with no refills. Delivery of such APRN healthcare services shall be within the APRN's advanced clinical nursing specialty area and a mutual SOP with the physician in addition to being consistent with the individual's skill, training, education, and competence. APRNs may receive/dispense samples within their Rx authority. A state Bureau of Narcotics and Dangerous Drugs number, as well as a DEA number, are required. Prescriptions written by an NP are labeled with both the collaborating physician's and NP's names.

Montana

bsd.dli.mt.gov/license/bsd_boards/nur_board/board_page.asp
mtnurses.org
campaignforaction.org/state/montana

■ Legal authority

The Montana BON grants APRNs authority to practice and regulates their practice. APRNs include the CNP, CNS, CNM, and CRNA roles. APRNs practice independently after completion of specific curriculum requirements and a national certifying exam by a BON-recognized national certifying body. According to the Montana BON, all APRNs involved in direct patient care must have an approved quality assurance program in place. APRN SOP is defined in Rule ARM 24.159.1406 with additional CNP SOP defined in Rule ARM 24.159.1470. APRNs are legally authorized to admit patients and hold hospital privileges; however, this varies according to the rules and bylaws of each hospital. APRNs licensed after 2008 must have a master's degree or postgraduate certificate from an accredited APRN program and hold national certification to enter into practice. All APRNs must maintain a quality assurance plan as part of the APRN Competence Development as defined.

■ Reimbursement

Medicaid reimburses APRNs at 85% of physician payment. Montana law requires indemnity plans to reimburse APRNs for all areas and services for which a policy would reimburse a physician; however, HMOs are not included in the indemnity insurers' law, mandatory coverage 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' compensation.

■ Prescriptive authority

APRNs who desire Rx authority must apply for recognition by the BON. APRNs with Rx authority are independently authorized to prescribe all medications, including Schedules II-V controlled substances using their own DEA number and are permitted to request, receive, and dispense drug samples. Additional CE for prescriptive authority is required for renewal every 2 years.

Nebraska

dhhs.ne.gov/publichealth/Pages/crl_nursing_nursingindex.aspx
www.nebraskanp.org
campaignforaction.org/state/nebraska

■ Legal authority

The Nebraska APRN Board grants APRNs the authority to practice and regulates their

practice. APRNs include the CNP (NP in statute), CNS, CNM, and CRNA roles. NPs and physicians practice collaboratively and have joint responsibility for patient care based on the SOP of each practitioner. The collaborative agreement is contained within the integrated practice agreement (IPA). An IPA specifies that, "The collaborating physician shall be responsible for supervision through ready availability for consultation and direction of the activities of the NP." If, after diligent effort, an NP is unable to obtain an IPA with a physician, the APRN Board may waive the requirement for an IPA if the NP 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.

NP's SOP is defined in statute and includes illness prevention, diagnosis, treatment, and management of common health problems and chronic conditions. "PCP" status and "any willing provider" language were not reported in the survey. NPs without minimum hours of specific coursework, a master's degree, a doctoral degree, and/or at least 2,000 hours of the physician-supervised practice must also have jointly approved protocols. Nebraska requires national board certification to enter practice.

■ **Reimbursement**

State legislation mandating third-party reimbursement for NPs does not exist; consequently, some NPs have been refused recognition as a provider. In 2008, BC/BS began reimbursing APRNs at 85% of the physician rate of reimbursement. Medicaid reimburses NPs at 100% of the physician payment.

■ **Prescriptive authority**

Nebraska NPs are authorized full prescriptive authority, including Schedules II-V medications as defined in their statute. NPs may request, receive, and dispense pharmaceutical samples if the samples are drugs within their prescribing authority. CRNAs prescribe within their specialty practice, and authority is implied in the statute. Qualified CRNAs, NPs, and CNMs may register for a DEA number. CNSs do not have prescriptive authority in Nebraska.

Nevada

www.nursingboard.state.nv.us
www.napna.net/Home_Page.php
www.nvnurses.org
campaignforaction.org/state/Nevada

■ **Legal authority**

The Nevada BON grants APRNs the authority to practice and regulates their practice.

APRNs include the CNP (NP in statute), CNS, CNM, and CRNA roles. APRNs who have been practicing for 2 years (or 2,000 hours) are granted full practice authority. New graduates or those practicing for less than 2 years (or 2,000 hours) are required to complete a transition to practice period, which includes a formal, written collaborative agreement with a physician with written protocols only if CS II medications are prescribed. APRN SOP is defined in the NPA and applicable regulations and includes the nationally established scope and standards for the APRN role. APRNs are not recognized as PCPs under state law; however, they are legally authorized to admit patients to the hospital and hold hospital privileges. If the applicant completed an APRN program after June 1, 2005, the applicant must hold a master's degree in nursing or related health field. Applicants requesting APRN licensure after July 14, 2014 must hold national certification.

■ **Reimbursement**

APRNs are recognized by insurance companies and receive third-party reimbursement. Reimbursement from private insurance is at the same rate as the physician payment; however, Medicaid reimbursement is available to all APRNs at 85% of the physician reimbursement.

■ **Prescriptive authority**

BON-authorized APRNs may prescribe controlled substances (CS II-V), 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. A collaborative agreement and protocols with a physician are only required for APRNs with less than 2 years or 2,000 hours of experience and only if prescribing CS II medications. APRNs register for their own DEA numbers. APRNs may pass a BON exam for dispensing and, after passing the exam with BON approval, apply to the BOP for a dispensing certificate. Samples are not considered "dispensing"; APRNs with prescriptive authority may receive and distribute samples without having dispensing authority.

New Hampshire

www.state.nh.us/nursing
nhnpa.enpnetwork.com
campaignforaction.org/state/new-hampshire

■ **Legal authority**

The New Hampshire BON grants APRNs authority to practice and regulates their practice. APRNs include the CNP, CNM, and CRNA roles. APRNs have full practice authority with their SOP defined in statute and do not require physician collaboration or

supervision. APRNs are statutorily recognized as "PCPs" in New Hemisphere; however, state law does not include "any willing provider" language. APRNs may admit patients and hold hospital privileges; however, this is institutionally driven. The minimum academic degree required to enter into practice is a master's degree in nursing, and national certification by a BON-recognized certification agency is required.

■ **Reimbursement**

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

■ **Prescriptive authority**

BON-licensed APRNs have plenary authority to possess, compound, prescribe, administer, dispense, and distribute controlled and noncontrolled medications within the scope of the APRN's practice. APRNs are assigned a DEA number on request, and are authorized to request, receive, and dispense pharmaceutical samples. Prescription labels are labeled with the APRN name.

New Jersey

www.state.nj.us/lps/ca/medical.htm
www.njsna.org
campaignforaction.org/state/new-jersey

■ **Legal authority**

The New Jersey BON grants APRNs authority to practice and regulates their practice. APRNs are defined as APNs in the state of New Jersey and include the CNP, CNS, and CRNA roles. APNs practice in collaboration with physicians and are required to have a joint protocol with the collaborating physician for prescribing drugs and devices only. SOP for APNs is defined in statute. APNs are recognized as "PCPs"; however, New Jersey does not have "any willing provider" language in statute. APNs are legally authorized to admit patients and hold hospital privileges, but this is not defined by statute or regulation. Privileges are determined through the credentialing/privileging process of individual healthcare institutions. APN applicants must be masters prepared in nursing, and national board certification is required to enter into practice in New Jersey.

■ **Reimbursement**

Private health plans, including Medicaid-managed-care plans, are permitted to

credentialed APNs as “PCPs” but not required to recognize or reimburse them. Once the APN has been credentialed by or has obtained a provider number from these insurers, the APN is recognized as an Independently Licensed Practitioner/Provider (ILP) and can be directly reimbursed by Medicare, New Jersey Medicaid, New Jersey FamilyCare, United Healthcare, and other Medicaid HMOs, including Cigna, Great West, Health Net, Amerigroup/Choice, QualCare, and Oxford. Aetna and Horizon BC/BS and some other Horizon MCOs will only credential and reimburse APNs who work in physician practices, not as ILPs providing primary care. Both Horizon and Aetna have fairly consistently credentialed and directly reimbursed Psychiatric APNs. Note that direct reimbursement to APNs is also provided by the Civilian Health and Medical Program (uniformed service members and their families). Where APNs are credentialed and directly reimbursed by private insurers, it is generally at 85% of the physician rate, mirroring Medicare.

■ Prescriptive authority

APNs credentialed by the BON have full prescriptive authority, including Schedules II-V controlled substances in accordance with a joint protocol, which has been established by the APN and the collaborating physician. The joint protocol is required for prescribing drugs and devices only and is not a collaborative agreement for general practice. To prescribe controlled substances, APNs must have both a state-controlled dangerous substance (CDS) number/federal DEA number and have modified the joint protocol to indicate whether or not prior consultation with the collaborating physician is necessary before initiating CDS prescriptions. All APNs in New Jersey must complete a one-time, 6-hour course in controlled substance prescribing. APNs are authorized to request, receive, and dispense pharmaceutical samples.

New Mexico

www.nmna.org
www.nmnp.org
campaignforaction.org/state/new-mexico

■ Legal authority

The New Mexico BON grants APRNs the authority to practice and regulates their practice. APRNs include the CNP, CNS, and CRNA roles. CNPs practice independently without physician supervision or collaboration requirements. CNP SOP is defined in statute 61.3.23.2 of Chapter 61, Article 3 of the New Mexico Statutes. CNPs are statutorily recognized as PCPs; however, New Mexico does not have “any willing provider”

language contained within the statutes. CNPs are legally authorized to hold admitting and hospital privileges and can serve as “acute, chronic, long-term, and end-of-life healthcare providers.” A master’s degree in nursing or higher and national board certification are 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 masters’ 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.

■ Reimbursement

Statutory authority for third-party reimbursement for NPs and CNSs 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. FPNs and PPNs receive Medicaid reimbursement at 85% of the 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. 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/administer therapeutic measures, including dangerous drugs and controlled substances within emergency procedures, perioperative 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 APRN’s name where appropriate.

New York

www.nysed.gov
www.thenpa.org
www.nysna.org
campaignforaction.org/state/new-york

■ Legal authority

The New York State Education Department grants CNP (NP in statute) authority to practice and regulates their practice pursuant to Title VIII, Article 139 of NYS Education Law. The term “Advanced Practice Registered Nurse” is not defined in New York statutes or regulation, however, effective September 2014, CNSs are recognized by the NY State Education Department and the BON. NPs and CNSs are licensed as RNs by the BON and certified by the State Education Department. Effective January 2015, NPs who have practiced more than 3,600 hours are no longer required to hold a collaborative practice agreement with a physician; however, NPs with greater than 3,600 hours of practice must attest to a collaborative relationship with a physician. NPs who have not practiced a minimum of 3,600 hours are legally required to practice in collaboration with physicians in accordance with a written practice agreement and written practice protocols until they complete this transition to practice period. The written practice 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 legally authorized to hold admitting privileges. A master’s degree in nursing is required to enter into practice; however, national board certification is not required. CNMs are not regulated or recognized by the BON but must complete a master’s or higher degree program in midwifery or a related field that is accredited by the American College of Nurse Midwives Division of Accreditation.

■ Reimbursement

NPs of all specialties may register as Medicaid providers so long as the collaborating physician is also a Medicaid Provider (including mental health NPs) and be reimbursed at 100% of the physician rate when billed under the physician provider, and 85% of the physician rate when billed directly as an NP provider. Nurses continue to be qualified 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 nonphysician 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" healthcare 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 coverage area of the health benefit plan and who is willing, capable, and can meet the terms and conditions for participation." NPs are included in the NYSHIP Empire Plan (insures 122,000 NYS Employees and their families) offered by the two largest State Employees Unions.

■ Prescriptive authority

NPs have full prescriptive authority, including Schedules II-V controlled substances. NPs may order drugs, devices, immunizing agents, tests, and procedures either independently if they have completed a minimum of 3,600 hours of practice or in accordance with the written practice agreement and practice protocols during the transition to practice period without physician 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 lab tests limited to the practice of midwifery; they can dispense pharmaceutical samples.

North Carolina

www.ncbon.com

www.ncnurses.org

campaignforaction.org/state/north-carolina

■ Legal authority

A Joint Subcommittee of the North Carolina BON and the North Carolina Medical Board grant CNPs the authority to practice and regulate their practice. CRNAs and CNSs are regulated solely by the BON and CNMs are regulated by the Midwifery Joint Committee. APRNs include the CNP (NP in statute), CRNA, CNS, and CNM roles and all APRNs are required to maintain a current unencumbered RN license. NPs legally practice under a supervisory relationship with a physician; however, this is referred to as a collaborative practice agreement. Collaborative practice must include a WCPA with a physician for continuous availability, not necessarily on-site, and ongoing supervision, consultation, collaboration, referral, and evaluation.

After the first 6 months of NP practice in which documented monthly meetings are required, NPs and physicians meet at least twice a year. 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.

State law does not prohibit NPs from having admitting privileges and hospital privileges; however, these are granted on a facility-by-facility basis. APRNs are required to hold a minimum of a master's degree in nursing (or related field depending on the role), and must be nationally certified to enter into practice. Although the CNS title is not protected in law or rule, the BON does provide for voluntary recognition. In 2014, regulations were drafted to require full recognition of CNS practice at the APRN level. If approved, the regulation will be effective January 1, 2015. All APRNs are allowed to form corporations with physicians; however, CRNAs can only incorporate with anesthesiologists.

■ Reimbursement

NPs/CNMs receive Medicaid reimbursement at 100% of the physician rate for primary care activities. NPs who are enrolled as psychiatric/mental health providers receive 85% of the physician rate. Statutory authority for third-party reimbursement for NPs provides direct reimbursement to NPs for services within their scope. Psychiatric/mental health CNS services are reimbursable by insurance. CRNA services are reimbursable by insurance.

■ 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/CNMs may refill legend drugs up to 1 year and may write controlled substance prescriptions for 30 days. Refills may be authorized according to federal DEA regulations. NPs/CNMs with controlled substances in their collaborative practice agreements must obtain a DEA number (in addition to their approval number issued at the time of their approval as NPs/CNMs). CRNAs and CNSs do not have prescriptive authority in North Carolina.

North Dakota

www.ndbon.org

ndnpa.org

campaignforaction.org/state/north-dakota

■ Legal authority

The North Dakota BON grants APRNs the authority to practice and regulates their

practice. Individuals are licensed as APRNs in one of the four roles: CNP, CNS, CNM, or CRNA. APRNs practice independently in North Dakota and their SOP is defined in regulation and must be consistent with their nursing education and certification. APRN applicants for initial licensure must have a graduate degree with a nursing focus or have completed educational requirements in effect when the applicant was initially licensed and hold national certification in an advanced nursing role.

■ Reimbursement

FNPs, PNP, and CNMs receive Medicaid reimbursement at 75% of the physician rate and CNMs at 85% of the physician rate. BCBSND reimburses CRNAs, CNMs, CNSs, and NPs based on the lesser of the provider's billed charges or 75% of the BC/BS physician payment system in effect at the time the services are rendered. Legislation passed in 2009 granted an NP authority to be a PCP within the Medicaid system. Any certified NP is eligible for a Medicaid provider number. State law authorizes reimbursement for health services provided in the scope of licensure by nurses with advanced licensure and mental health in their SOP. APRNs are statutorily recognized as PCPs. Providers practicing more than 20 miles from Williston, Dickson, Minot, Bismarck, Jamestown, Devils Lake, Grand Forks, Wahpeton, and Fargo shall be reimbursed the lesser of provider's billed charges or 85% of the BCBSND physician payment system(s) in effect at the time services are rendered.

■ Prescriptive authority

Authorized APRNs may prescribe, administer, sign for, dispense over the counter, legend and controlled substances and procure pharmaceuticals, including sample legend drugs and Schedules II-V controlled substances. For prescriptive authority, the APRN must submit an application to the BON and meet the requirements outlined in NDAC section 54-05-03.1-09. APRNs with prescriptive authority may apply for a DEA number.

Ohio

www.nursing.ohio.gov

www.oaapn.org

campaignforaction.org/state/ohio

■ Legal authority

The Ohio BON grants APRNs the authority to practice and regulates their practice. APRNs include the CNP, CRNA, CNM, and CNS roles. Legal authority to practice requires a collaborative practice arrangement between a physician and a CNP, CNM, or CNS in the form of a standard care arrangement (practice agreement). CRNAs are required to

practice with a supervising physician. The SOP for CNPs is defined in statute ORC 4723.43. CNPs are statutorily recognized as providing preventive and primary care services, services for acute illnesses, and evaluation and promotion of patient wellness. Currently, CNPs, CNSs, and CNMs do not have legal authority to admit patients; however, many hospitals allow APRNs to hold hospital privileges. 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 and hold national certification to enter into practice.

■ Reimbursement

Ohio's Medicaid program recognizes CNPs certified in family, adult, acute care, geriatric, neonatal, pediatric, women's health/OB. It also recognizes CNMs, CRNAs, and CNSs certified in gerontology, medical-surgical, and oncology nursing specialties. MCOs vary on empanelment. There are no legislative restrictions for an APN to be listed on managed-care panels; 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, including Schedules II-V controlled substances under rules and in collaboration with a physician. A separate approval process is required to apply for prescriptive authority following a 1,500-hour externship period after graduation from an APRN program. APRNs with prescriptive authority in another state who meet Ohio's BON requirements may need to complete a limited externship or none at all, depending on the prior prescribing practices.

APRNs prescribe based upon a formulary developed and approved by the Interdisciplinary Committee on Prescriptive Governance. APRNs 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 prescribing of schedule II controlled substances is limited to those prescriptions issued through specific institutions and programs recognized in Ohio nursing law, and as consistent with the APRN's standard care arrangement.

APRNs that are not practicing in an institution or program recognized in law are limited in their schedule II controlled substance prescribing to the care of terminally ill patients after physician initiation and only for a 24-hour period. DEA registration is required. Prescriptions are labeled

with the name of the prescriber. APRNs with Rx authority may request, receive, sign for, and distribute sample medications that are not controlled substances in a 72-hour supply, except when minimum available quantity of the sample is packaged in an amount greater than a 72-hour supply. All samples provided must be consistent with APRN's scope and within the formulary.

Oklahoma

www.lsb.state.ok.us
www.ok.gov/nursing
campaignforaction.org/state/oklahoma

■ Legal authority

The Oklahoma BON grants APRNs the authority to practice and regulates their practice. APRNs include the CNP, CNS, CNM, and CRNA roles. CNPs function independently with the exception of prescriptive authority, which requires supervision by a physician. APRNs practice within an SOP as defined by the NPA. The SOP for a CNP is further identified in specialty categories that delineate the population served, such as Adult-Gerontology, Family/Individual across the Lifespan, and so forth. CNSs must hold a master's degree in nursing, and CNPs/CNSs must be nationally board certified to enter into practice. Effective January 1, 2016, the APRN applicants shall have completed an accredited graduate-level APRN education program in at least one of the following population foci: family/individual across the lifespan, adult gerontology, neonatal, pediatrics, women's health/gender-related, or psychiatric/mental health.

■ Reimbursement

Oklahoma's Medicaid plan includes CNPs as "primary care managers." State law does not mandate reimbursement of CNPs; however, the Oklahoma State and Education Employees Insurance Company recognizes CNPs as providers. Negotiation continues with other third-party insurers.

■ Prescriptive authority

The BON regulates optional prescriptive authority for CNPs, 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 the following: must not be on the exclusionary formulary approved by the board; must be within the CNP, CNM, and CNS SOP; include Schedules III-V controlled substances (30-day supply) if state Oklahoma Bureau of Narcotics and Dangerous Drugs (OBND) and DEA registrations are obtained; and include signing to receive drug samples. CNPs, 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. In addition, they also need 15 contact hours or 1 academic hour every 2 years for renewal. A CRNA may order, select, obtain, and administer drugs only during the perioperative or peri-obstetrical period. 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 OBND and DEA registrations to order Schedules II-V controlled substances.

Oregon

www.oregon.gov/OSBN
www.oregonrn.org
www.oregoncenterfornursing.org/index.php?mode=cms&pageld=onlc

■ Legal authority

The Oregon BON grants full practice authority to and regulates CNPs (NP title in regulation; CNMs are a category of NP), CNSs, and CRNAs. Nurses in all the three categories of advanced practice must be credentialed with a certificate by the BON. "APRN" is not a protected title in the Oregon NPA. SOP is defined in regulation, Division 50, 52 and 54 of the NPA. NPs are statutorily recognized as PCPs, 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 in nursing or doctoral degree in nursing is required for the CNS entry into practice, and is also required for the NP or CRNA educated after specific dates (see regulations for further information). National board certification is required to enter into practice as of January 1, 2011.

■ Reimbursement

NPs are entitled by law to reimbursement by third-party payers. APRNs 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. Recent passage of HB 2902 in 2013 provides payment parity from private insurers for NPs in independent practice. Numerous administrative rules and statutes include NPs, such as special education physical exams (Department of Education) and chronically ill and disabled motorist exams (Department of Motor Vehicles).

■ Prescriptive authority

Regulation of Rx authority is under the sole authority of the BON. Oregon has legislated

independent or plenary authority for NPs and CNSs to prescribe, so NPs and CNSs are able to obtain DEA numbers for Schedules II to V. NPs and CNSs with prescription-writing authority may receive and distribute prepackaged complimentary drug samples. NPs and CNSs may apply to the BON for unencumbered drug-dispensing authority. NPs do not have authority to prescribe under the physician-assisted suicide law. Only physicians can authorize medical marijuana use. Division 52 addresses prescriptive authority for CRNAs, effective 2013.

Pennsylvania

www.dos.state.pa.us/nurse

www.pacnp.org

campaignforaction.org/state/Pennsylvania

■ Legal authority

The Pennsylvania BON grants CRNPs and CNSs authority to practice and regulates their practice. APRN is not defined in statute or regulation. A CRNP performs the expanded role in collaboration with a physician, which 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 CRNP's SOP is defined in statute and regulation. CRNPs are recognized as PCPs by DPW and many insurance companies, but there are some managed-care companies who do not recognize CRNPs as PCPs. The Pennsylvania Department of Health Regulations 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 have a master's degree and pass a national certification exam. 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 enterostomal 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 the 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 Schedules II to 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 and conforms with regulations. The CRNP may write a prescription for a Schedule II controlled substance for up to a 30-day supply. CRNPs may prescribe Schedules III to IV medications for up to a 90-day supply; Schedule V is not restricted. CRNPs are authorized to request, receive, and dispense pharmaceutical sample medications. Prescription blanks must include the name, title, and Pennsylvania certification number of the CRNP. The collaborative agreement is a signed, written agreement between the CRNP and a collaborating physician in which they agree to the details of their collaboration, including the elements in the definition of Collaboration.

Rhode Island

www.health.ri.gov/for/nurses

npari.enpnetwork.com

campaignforaction.org/state/rhode-island

■ Legal authority

The Rhode Island BON grants APRNs full practice authority and regulates their practice. APRNs include the CNP, CNS, and CRNA roles. CNMs are licensed and regulated under separate R&Rs; not regulated by the BON. SOP is defined within the NPA. CNPs are statutorily recognized as "PCPs" 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. APRNs are considered licensed independent practitioners in this state. The minimum degree to enter into practice for all APRNs is completion of a graduate or postgraduate-level APRN program and national board certification (certain exceptions apply).

■ Reimbursement

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

■ Prescriptive authority

With the passage of S614 in 2013, APRNs are granted independent prescriptive authority, including authority to prescribe, order, procure, administer, dispense and furnish over the counter, legend and controlled substances (General Laws in Chapter 5-34, Section 5-34-49) within their APRN role and population focus. CNPs may also be authorized to apply for CS II–V and may be certified to prescribe CS from Schedule I. CRNA, CNS, and APRNs in mental health prescribe pursuant to Chapter 5-34, Section 5-34-49 (e) (f) and (g).

South Carolina

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

scnurses.org

campaignforaction.org/state/south-carolina

■ Legal authority

The South Carolina BON grants APRNs the authority to practice and regulates their practice. APRNs include the CNP, CNS, CNM, and CRNA roles. 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 NPs, CNSs, and CNMs 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, CNSs, and CNMs who manage delegated medical aspects of care must have a supervising physician who can be accessed by electronic/telephonic 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 doctorate, postmaster's certificate, or a minimum of 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 (now the NPI number), are paid 85% of the physician payment rate, and are recognized as "PCPs." The State Health and Human Services finance commissioner requires that NPs have current, accurate, and detailed treatment plans. Approximately 23 payers recognize, enroll, and directly reimburse APRNs for services provided. Dr. Stephanie Burgess is the first APRN to sit on the advisory board for State Health and Human Services Board in

South Carolina, while the rest of the Board consists of MDs.

■ Prescriptive authority

NPs, CNSs, and CNMs have prescriptive authority, including Schedule III-V controlled substances, and prescribe according to practice agreement/protocol within the specialty area of the APRN. CRNAs are not required to obtain prescriptive authority to deliver anesthesia care; however, CRNAs practice pursuant to approved written guidelines with a supervising physician, dentist, or medical staff. The BON issues an ID number to the nurse authorized to prescribe. State law requires prescriptions by NPs be signed by the NP, contain the NP's BON-assigned prescriptive authority number and place of practice, and the physician's name and address preprinted on the prescription blank. APRNs with prescriptive authority may request, receive, and sign for professional samples, including Schedule III-V controlled substances.

South Dakota

<http://doh.sd.gov/Boards/Nursing/campaignforaction.org/state/south-dakota>

■ Legal authority

The South Dakota BON and BOM jointly regulate the practice of CNPs and CNMs. APRNs include the CNP, CNS, CNM, and CRNA roles. 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 occurs no less than twice each month unless a modification request is approved to allow one of the twice-monthly meetings held by the telecommunication. CNSs are regulated by the BON, and physician supervision is not required; however, before 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, and APNs are granted hospital privileges. CNPs and CNMs must hold a graduate degree in nursing and national certification to enter into practice. CRNAs and CNSs must complete an approved program of nurse anesthesia or graduate program in nursing and hold national certification unless exempted as specified.

■ 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 must 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 Schedule II to IV controlled substances as authorized by the collaborating physician agreement. CNPs and CNMs have two controlled substance registration options: they may seek independent state registration and independent DEA registration in all Schedules as authorized by their collaborative agreement; or 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, 30-day supply. Therefore, the amount provided is at the professional discretion of the CNP, 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, however, CNSs may order and dispense durable medical equipment and therapeutic devices in collaboration with a physician.

Tennessee

www.tnaonline.org/health.state.tn.us/Boards/Nursing/campaignforaction.org/state/tennessee

■ Legal authority

The Tennessee BON grants ARPNS authority to practice and regulates their practice.

ARPNS are defined as APNs in regulation and include the CNP (NP in regulation), CNS, CNM, and CRNA roles. APNs meeting requirements for prescriptive authority are eligible for a certificate that is designated "with certificate to prescribe." 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 CNMs are defined in the hospital licensure rules, which also provide that the medical staff may include CNMs; CNMs 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. APNs are required to hold a master's degree or higher in a nursing specialty and national certification to enter into practice in this state.

■ Reimbursement

Tennessee's private insurance laws mandate reimbursement of APNs. A managed-care antidiscrimination law prevents MCO 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 MCOs participating in the TennCare program also credential APNs and assign an established patient panel upon individual review of specialty.

■ Prescriptive authority

APNs who have a BON-issued certificate to prescribe may prescribe legend and schedule II to V controlled substances pursuant to protocols. Preauthorization is required for off-formulary medications and for CS II or III opioid prescriptions more than 30-day supply. Prescribers must also now confer with the CS database prior to issuing a prescription for opioids or benzodiazepines

as a new course of treatment that will last more than 7 days and at least annually when the CS medication remains part of ongoing treatment. Both the supervising physician's name and address must be printed on the prescription blank; however, the APN may sign the prescription. NPs may request, receive, and issue pharmaceutical samples.

Texas

www.bon.state.tx.us
www.cnaptexas.org
www.texasnp.org
campaignforaction.org/state/texas

■ Legal authority

The BON is authorized by the NPA to regulate APRNs. APRNs are licensed in one or more of the following recognized roles: NP, CNS, CNM, or CRNA. The APRN's SOP is based on advanced practice education, experience, and the accepted SOP of the associated population focus area. The APRN acts independently and/or in collaboration with the healthcare team. The authority to make a medical diagnosis and write Rx must be delegated by an MD or DO using written delegation protocols or other written authorization. The rules define protocols as written authorization to provide medical aspects of care. Protocols should allow the APRN to exercise professional judgment and are not required to outline specific steps the APRN must take, but they are required to contain certain elements regarding prescriptive authority. Hospitals may extend privileges to APRNs but are not required to do so. Hospitals electing to extend clinical privileges to APRNs must use a standard application form and afford due process rights in granting, modifying, or revoking those privileges.

■ Reimbursement

All APRN categories are eligible for direct Medicaid reimbursement at 92% of physician payment. Under certain circumstances, physicians in the Texas Medicaid Program may bill for an APRN's services and receive 100%. Some programs such as Texas Health Steps reimburse all providers at the same rate. NPs can be PCPs in Texas Medicaid-managed-care plans. APRNs are listed in the Texas Insurance Code as practitioners who must be reimbursed by indemnity health insurance plans. All HMOs and PPOs in Texas must list an APRN on provider panels if the APRN's collaborating physician is on the panel and the physician requests that the APRN also be listed.

■ Prescriptive authority

APRNs may be delegated prescriptive authority by a physician, which includes

nonprescription, legend, and CS II-V medications under certain circumstances contained within 22 Texas Administrative Code §222. CS III-V authority may be delegated with the following limitations: APRNs may only Rx a maximum 90-day supply; the APRN must consult with the physician before authorizing a refill; and APRNs may not Rx controlled substances to a child less than 2 years without physician consultation, which must be noted in the chart.

CS II authority may be delegated to an APRN when prescribing in a hospital-based facility to a patient who has been admitted for a period of 24 hours or greater; is receiving services in the ED; or as part of the plan of care for treatment of a patient receiving hospice care. The ratio of supervision has been increased to 1:7 (physician to APRNs and/or PAs); however, the supervision ratio does not apply to the prescriptive authority agreement when prescriptive authority is delegated in a medically underserved area or a hospital-based facility. APRNs with prescriptive authority may request, receive, possess, and distribute samples of drugs they are authorized to prescribe.

Utah

www.dopl.utah.gov/index.html
utahnp.enpnetwork.com
campaignforaction.org/state/utah

■ Legal authority

The Utah BON, in collaboration with the Division of Occupational and Professional Licensing, grants authority to practice via licensure with an "APRN" or "APRN-CRNA without prescriptive practice" license and regulates the practice of APRNs and CRNAs, pursuant to the Utah Nurse Practice Act, Part 3, 58-31b-301. Licensed APRN roles include the CNP, CNS, psychiatric/mental health nurse, CNM, and CRNA. CNMs are regulated by a separate practice act and CNM board. APRNs practice independently without physician supervision or collaboration with the exception of CS II-III authority (see below).

The APRN SOP is defined by set standards from national, professional, specialty organizations, and APRNs are not statutorily prohibited from admitting patients and holding hospital privileges; however, this is decided upon by the individual institution. All APRNs must hold a master's degree prepared or higher and nationally certified to obtain licensure. During the 2004 legislative session, the Utah Legislature was the first legislature to adopt the APRN compact.

■ Reimbursement

The state insurance code has a nondiscrimination code; nothing prohibits reimbursement. APRNs are reimbursed by most insurance companies. As of April 2014, Medicaid empanels and reimbursed all board-certified NP specialties (previously FNP and PNP only) at 100% of the physician rate. CNMs are reimbursed by Medicare and Medicaid at 100% of the physician rate, whereas other APRN roles receive reimbursement at 80% of the physician rate.

■ Prescriptive authority

APRNs including CNMs have prescriptive authority for all legend drugs and devices, including Schedules IV to V controlled substances within their SOP. A consultation and referral plan is required by the NPA if prescribing Schedules II or III controlled substances. APRN-CRNAs do not require a consultation or referral plan for their practice. CRNAs may order and administer drugs, including Schedules II to V controlled substances in a hospital or ambulatory care setting; they may not provide prescriptions to be filled outside the hospital. APRNs including CNMs and CRNAs receive a DEA number after passing a controlled substance exam and obtaining a state-controlled substance license; CRNAs may use facility DEA numbers under certain conditions. APRNs and CNMs may sign for and dispense drug samples.

Vermont

www.sec.state.vt.us/professionalregulation/professions/nursing.aspx
www.vtnpa.org
campaignforaction.org/state/vermont

■ Legal authority

The Vermont BON grants APRNs the authority to practice and regulates their practice. APRNs include the CNP (NP in regulation), CNS in Psychiatric & Mental Health Nursing, CNM, CRNA roles. APRNs are independent providers after a transition to practice requirement is met (2,400 hours and 2 years) with a SOP defined in statute and regulations. 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. 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 to V controlled substances within their practice guidelines. APRNs have the same privileges dispensing and administering drugs as physicians. NPs register for their own, receive DEA numbers, and are authorized to request, receive, and/or dispense pharmaceutical samples. Prescriptions are labeled with the APRN's name.

Virginia

www.dhp.virginia.gov

www.vcnp.net

campaignforaction.org/state/virginia

■ Legal authority

The Virginia BON and BOM have joint statutory authority to regulate licensed NPs (LNPs). LNPs are defined as APRNs and include the NP, CNM, and CRNA roles. CNSs are registered solely with the BON and are not defined as APRNs. LNPs licensed in a category other than CRNA practice in collaboration and consultation with a Patient Care Team Physician as part of a Patient Care Team. CRNA practice remains under the supervision of a physician. NP practice is based on education, certification, and a written practice agreement and NPs are included in the list of professions authorized to perform surgery. According to the Virginia BON, NPs are not statutorily prevented from being PCPs, and no law or regulation prevents them from admitting patients to the hospital and holding hospital privileges. Virginia state law does not include NPs in its "any willing provider" language. A master's degree in nursing and national board certification are required to enter into practice in Virginia. Among other things, NPs are also authorized to certify medical necessity of durable medical equipment that is to be reimbursed by Medicaid.

■ Reimbursement

Board-certified NPs and CNMs are reimbursed by Medicaid at 100% of the physician rate. Psychiatric NPs are paid the same rate for psychiatric diagnosis, evaluation, and psychotherapy services as a PCNS, which is 67% of the rate currently paid to Medicaid enrolled psychiatrists. For other procedures such as physical exams, psychiatric NPs will be reimbursed at the same rate as other NPs. NPs can independently bill insurers; however, payment is dependent upon individual company policy. Virginia has an "any willing provider" law, but it applies only to mandated providers and, among APNs, only PCNSs and CNMs are mandated providers. CNMs and CNSs in psychiatric health receive third-party reimbursement.

■ Prescriptive authority

Authorized LNPs may prescribe all legend drugs including Schedules II to V controlled substances as defined in the LNP's Practice Agreement. A Practice Agreement, developed between the NP and the Patient Care Team Physician and maintained by the NP (which is to be provided to the Joint Boards of Nursing and Medicine upon request), lists the drug categories the NP will prescribe. NPs may only prescribe legend drugs if "such prescription is authorized by the Practice Agreement between the NP and physician." The prescription must include the NP's name and prescriptive authority number.

The name and contact information of the collaborating physician shall be provided to the patient upon request. Physicians who enter into a Practice Agreement with an LNP may only collaborate at any one time, with up to six NPs with prescriptive authority. Periodic electronic or chart review is required and physician collaboration and consultation may be satisfied via telemedicine. The joint regulations of the BON and BOM include requirements for continued NP competency, including 8 hours of CE in pharmacology or pharmacotherapeutics for each biennium. 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."

Washington

www.doh.wa.gov/

LicensesPermitsandCertificates/NursingCommission.aspx

www.auws.org

www.wsna.org

campaignforaction.org/state/washington

■ Legal authority

The Nursing Care Quality Assurance Commission grants APRNs the authority to practice and regulates their practice; APRNs are designated as "ARNPs" in statute and regulation, which include the NP, CNM, and CRNA roles. ARNP practice is independent, and ARNPs assume primary responsibility for continuous and comprehensive management of a broad range of patient care, concerns, and problems. The SOP for ARNPs is defined in statute and regulation. ARNPs are statutorily defined as PCPs and are legally authorized to admit patients to a hospital and hold hospital privileges. However, hospitals and medical staff have the right to make the

decision on credentialing. A graduate degree and national certification is required to obtain licensure as an ARNP in Washington.

■ Reimbursement

Medicaid reimbursement is available to ARNPs at 100% of the physician payment. Labor and Industries reimbursement is at 90% of the physician payment. The Healthcare Service Contracts Act (RCW 48.44.290) makes it illegal to deny a healthcare service performed by an RN or ARNP within the person's SOP if the healthcare contract would have approved the same service performed by a physician. A court ruled that the law's use of the term "healthcare service contract" referred to contracts between the health plan and the insured individual and did not extend to the healthcare provider. The court ruled that the law did not have legal force in addressing reimbursement parity for ARNPs because it only applied to the agreement between the health plan and the patient. Consequently, many private insurance companies reimburse ARNPs at a lower rate than a physician for the same service.

■ Prescriptive authority

All ARNPs who receive prescriptive authority may independently prescribe legend drugs and Schedule II to V controlled substances. Independent prescriptive authority requires an initial 30 contact hours of education in pharmacotherapeutics (within the applicant's SOP) obtained within the 2-year period, immediately prior to application. An advanced pharmacology course, taken as a part of the graduate program, meets the requirement if the application is made within 2 years of graduation. Renewal of Rx authority every 2 years requires 15 hours of pharmacotherapeutic education within the area of practice. ARNPs are legally authorized to request, receive, and dispense pharmaceutical samples, and prescriptions are labeled with the ARNP's name.

West Virginia

wvrnboard.com

campaignforaction.org/state/west-virginia

■ Legal authority

The West Virginia BON grants authority to practice and regulates the practice of APRNs; law defines advanced practice for RNs. APRNs include the NP, CNS, CNM, and CRNA roles. ARNP SOP includes the ability to assess, conceptualize, diagnose, analyze, plan, implement, and evaluate complex problems related to health. The ARNP SOP does not require collaboration with a physician unless the ARNP is prescribing, with the exception of CNMs who are required

to practice in a collaborative relationship with a physician with or without prescriptive authority. CRNAs administer anesthesia in the presence and under the supervision of a physician or Doctor of Dental Surgery. Hospital credentialing for APRNs is dependent upon individual hospital policy. APRNs must have graduated from an accredited graduate program and be nationally board certified to enter into practice in the State of West Virginia.

■ Reimbursement

Family, pediatric, gerontologic, adult, women's health, and psychiatric NPs receive Medicaid reimbursement at 100% of the physician rate. State law requires insurance companies to reimburse nurses for their services, if such services are commonly reimbursed for other providers; however, rules and regulations have not been promulgated. NPs and CNMs are defined as PCPs: 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 Healthcare Bill provided for direct access, at least annually, to a woman's healthcare provider for a well-woman exam. Providers include APRNs, NPs, CNMs, FNPs, WHNPs, adult NPs, GNPs, or PNPs.

■ Prescriptive authority

Qualified APRNs have prescriptive authority requiring a collaborative relationship with a licensed physician. Prescriptive authority includes Schedule III to V controlled substances with some restrictions. Rules and regulations specify that the APRNs must meet specified pharmacology education requirements and certify that they have a written collaborating agreement with a physician or osteopath. The written collaborative agreement must include guidelines or protocols describing the individual and shared responsibility between the APRNs and physician with periodic joint evaluation of the practice and review/updates of the written guidelines or protocols. No supervision requirement exists; APRNs are not required to be employed by a collaborating physician. The APRN works from an exclusionary formulary.

Schedules I and II, antineoplastics, radiopharmaceuticals, and general anesthetics are prohibited. Monoamine oxidase inhibitors are excluded except when

in a collaborative agreement with a psychiatrist. Additional changes include the increase in amount of CS IV and V medications that may be prescribed. Prior to the initial provision of pain-relieving CS, the APRN must access the West Virginia Controlled Substances Monitoring Program repository and database to determine if the patient has obtained any CS from another prescriber within the 12-month period preceding the current visit. This must be documented and must be accessed by the current prescriber at least annually when treating a chronic pain condition. A DEA number is issued directly to APRNs by the DEA, and APRNs are authorized to sign for and provide drug samples.

Wisconsin

www.wisconsinnurses.org
www.dsps.wi.gov/Default.aspx?Page=582ce3ce-0028-404c-9373-14bfd6cf17c8
campaignforaction.org/state/wisconsin

■ Legal authority

The Wisconsin BON regulates the practice of APRNs defined as Advanced Practice Nurse Prescribers (APNPs) and includes the CNP, CNS, CNM, and CRNA roles. SOP is not defined in statute for NPs, CNSs, or CRNAs with the exception of reference to prescriptive authority (Wisconsin Rule §N 8.10); however, SOP is defined in statute and rules for CNMs (Wisconsin Stat. §441.15(1)(b) and Wisconsin Administrative Rule § N4.06). APNPs must practice in a collaborative relationship with a physician. There are no statutory requirements for hospitals to grant staff privileges, and few have done so. Regulations require all patients to be "under the care of a physician, dentist, or podiatrist." An APNP must have a master's degree in nursing or related field, national board certification, malpractice insurance (\$1 million/\$3 million), and 45 required, clinical pharmacology hours to enter into practice in Wisconsin.

■ Reimbursement

Specified, reimbursable billing codes have Medicaid reimbursement of 100% as submitted by all master's degree-prepared NPs or NPs who are certified. 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, and 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 PCP of record.

■ Prescriptive authority

Eligible APNPs may prescribe legend drugs and controlled substances Schedules II to V as a delegated medical act under the NPA. Wisconsin Administrative Rule §N 8.06 describes limitations on prescriptive authority for CS II medications. APNPs may dispense complementary pharmaceutical samples; the APNP may also dispense drugs to a patient if the treatment facility is located at least 30 miles from the nearest pharmacy.

Wyoming

nursing.state.wy.us
wyonurse.org
campaignforaction.org/state/wyoming

■ Legal authority

The Wyoming BON grants APRNs the authority to practice and regulates their practice. APRNs include the CNP, CNS, CNM, and CRNA roles. 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 nurse practice act, and includes prescriptive authority and management of patients commensurate with national organizations and accrediting agencies. "APRNs are statutorily defined as 'PCPs' and may be permitted to admit patients to a hospital and hold hospital privileges, depending on individual hospital policies." A master's degree in nursing in a specific APRN role and national board certification in that role are required to enter into practice as an APRN in Wyoming.

■ Reimbursement

APRNs are authorized to receive Medicaid payments at 100% of physician payment. All PCPs may receive third-party payment; however, policies differ among third-party payers. Wyoming State BON has no say in reimbursement policies.

■ Prescriptive authority

BON-approved APRNs may independently prescribe legend and Schedule II to 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. This is not addressed by the BON but possibly the Pharmacy Board, and prescriptions are labeled with the APRN name. 