Alabama

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

Legal Authority

The BON has sole authority to establish the qualifications and certification requirements of APNs through R&Rs. APNs are defined as CRNPs, CNMs, CRNAs, and CNSs. CNSs and CRNAs are not regulated by the joint committee (BON and BOME), and are not eligible for prescriptive authority. The BON and BOME regulate the collaborative practice of physicians, CRNPs, and CNMs and require them to practice with BON- and BOME-approved protocols. The collaborating physician and NP or CNM practicing with the physician must sign the protocol. "The term 'collaboration' does not require direct, on-site supervision of the activities of a CRNP or CNM by the collaborating physician. The term does require such professional oversight and direction as may be required by the R&R of the 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's or CNM's collaboration time is 30 or more hours per week) and a minimum of 10% on a quarterly basis (if the collaboration time is less than 30 hours per week). Proposed rules in promulgation September 2006 define "remote practice site," where the collaborating physician must visit each remote site at least quarterly. The APN shall practice in accordance with national standards and functions identified by the appropriate specialty-certifying agency and as congruent with Alabama law. CRNP scope of practice is defined in statute and regulation. Alabama does not recognize APNs as "PCPs" and does not have "any willing provider" language in statute. CRNPs are required to have an MSN and national certification on entry into practice, with a few exceptions: initial CRNP applicants are exempt from requirement for MSN on discretion of the BON if graduation was prior to 1996 in a post-BSN NP program, or graduation prior to 1984 from a non-BSN program preparing NPs. CRNAs must have a minimum of a master's degree from an accredited nurse anesthesia graduate program and be currently certified as a CRNA; CRNAs who graduated prior to December 31, 2003, are exempt from the master's degree requirement. CNS approval requires MSN as a CNS and national certification.

Reimbursement

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

Alaska

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

Legal Authority

ANPs are regulated by the Alaska BON. ANPs include NPs and CNMs and are defined as an RN who, because of specialized education and experience, is certified to perform acts of medical diagnosis and prescription, as well as dispense medical, therapeutic, or corrective measures under regulations adopted by the BON. Regulations require that an 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; however, hospitals require a physician preceptor with the exception of the Federal Alaska Native Hospital. Entry into NP practice requires a master's degree in nursing and national board certification. Continuing education requirements for ANPs are 30 CEUs (8 of these must be Rx hours) every 2 years. CRNAs practice under separate rules and regulations, and CNSs are not licensed or recognized separately from their RN license.

Reimbursement

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

Prescriptive Authority

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

Arizona

http://www.azboardofnursing.org
http://www.azbn.gov

2007 Legislative Activity

SB 1100 passed in February 2007 and was signed into law by the governor in April. SB 1100 provides statutory authority to Nurse Practitioners to provide a variety of services. These are services that were already in the SOP of a registered nurse practitioner; the bill updated the Arizona Revised Statues in the respective areas so that NP was added to the list of authorized providers.

Legal Authority

The Arizona BON grants APRNs authority and regulates their practice. APRNs are defined as RNPs, which include NPs (inclusive of CNSs) and CNMs. According to the BON, a RNP will refer a patient to a physician or other healthcare provider if a situation or condition occurs in a patient that is beyond the RNP's knowledge and experience. No formal collaboration agreement is required. RNP SOP is defined in regulation R4-19-507. RNPs are not statutorily recognized as "PCPs"; however, they are legally authorized to hold admitting and hospital privileges through R&Rs. RNPs must have a graduate degree in nursing and national certification to enter into practice.

Reimbursement
RNPs and other certified RNs may receive third-party reimbursement, enabled by the Department of Insurance statutes. There is no Medicaid; the Arizona Health Care Cost Containment System (AHCCCS) contracts with MCOs and other provider networks on a capitated basis. AHCCCS NP reimbursement is 90% of the established physician rate.

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

Arkansas
http://www.arsbn.org
http://www.arna.org/

Legal Authority
The BON grants APNs authority to practice via second licensure, separate from RN licensure. APNs are licensed and defined as an ANP, CNM, CNS, or CRNA. APNs practice independently with the exception of NPs who are not nationally certified. NPs who are not nationally certified qualify for licensure as an RNP; however, they must practice under physician direction/protocol. Hospital privileges for APNs are determined on a hospital-to-hospital basis according to the credentialing committee of each hospital. In 2005, "Any Willing Provider" language was enacted. Graduate-level APN education and national board certification is required for initial APN licensure.

Reimbursement
The NPA mandates direct Medicaid reimbursement to APNs and RNPs. Medicaid reimbursement is 80% of a physicians' rate. APNs are not recognized as PCPs for Medicaid. CNMs and some NPs are listed on managed care panels. APNs are included in the any willing provider law that was upheld in the 8th Circuit Court of Appeals. A statutory provision exists for third-party reimbursement for CRNAs.

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

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

✪ 2007 Legislative Activity
AB 139 (Bass): Governor Schwarzenegger signed AB 139, authorizing NPs and physician assistants to perform physical examinations for the purposes of obtaining a drivers license to operate a farm labor vehicle, paratransit vehicle, or bus.

SB 102 (Migden): SB 102 passed and was signed into law authorizing NPs, physician assistants and CNMs to consent a patient for blood transfusion.

AB 1436 (Hernandez): NP scope of practice bill seeks to define the scope of practice in California for NPs. Current law and regulation does not address NP scope separate from that of a registered nurse. This is a 2-year bill. Other changes included in this bill include the requirement of national certification as entry into practice.

SB 236 (Runner): This is the republican caucus healthcare reform bill which states the legislative intent to enact laws pertaining to healthcare reform. Included in the language is the statement, "To allow NPs to establish and run primary health clinics." This is a 2-year bill.

The California Association for Nurse Practitioners is in active negotiation and discussion with Governor Schwarzenegger, Assembly Speaker Fabian Nunez, and Senate Pro tem Don Perata on NP inclusion in the healthcare reform debate. The 2008 legislative session will be very busy with healthcare reform in California.

Legal Authority
The California BRN grants legal authority to practice, regulates, and issues separate certification to APRNs. APRNs are defined as NPs, CNMs, CRNAs, and CNSs. California is a supervisory state; however, "supervision" does not require the physical presence of a physician. NPs function under "standardized procedures" or protocols when performing medical functions, which are collaboratively developed and approved by the NP, physician, and administration in the organized healthcare facility in which they work. The SOP of a NP is defined within their standardized procedures, not in statute or regulation. NPs and CNMs are statutorily recognized as "Primary Care Providers" in California's Medi-Cal system. APNs are not legally authorized to admit patients to the hospital; however, individual hospitals may grant hospital privileges to APRNs. NPs entering practice after January 1, 2008 must have a master's degree to practice; however, California does not require national certification to practice.

Reimbursement
All nationally board-certified nurse practitioners are reimbursed independently by the Medi-Cal system. Medi-Cal-covered services performed by NPs, CNMs, and CRNAs are reimbursed at 100% of the physician reimbursement rate. Blue Cross of CA Medi-Cal Provider Directory lists NPs as PCPs under their area specialty. There is no legal preclusion to third-party reimbursement of services; however, policies vary from payer to payer. Third-party payers are legally required, however, to reimburse BRN-listed psychiatric-mental health nurses for qualifying services. Participants in the state's managed care programs for specified Medi-Cal beneficiaries may select NPs and CNMs as their PCPs.

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

Colorado
http://www.dora.state.co.us/nursing
http://www.nurses-co.org/

Legal Authority
The Colorado BON grants APNs legal authority to practice and also regulates their practice. Title protection is provided to APNs, defined as

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

Reimbursement

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

Prescriptive Authority

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

Connecticut

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

✪ 2007 Legislative Activity

PA-06-195 passed, permitting a graduate APRN to work without a license for 120 days after graduating in a hospital or other setting under the supervision of a physician or other APRN. The APRN may not prescribe or dispense drugs, and the hospital or other setting must verify that the graduate has applied to take a national certification exam and must end his work if notified that the graduate has failed the exam.

PA-06-169 became effective October 2006 allowing APRNs to prescribe, dispense, and administer medical therapeutics and corrective measures in collaboration in all settings.

Legal Authority

The Connecticut NPA defines APRNs as NPs, CNSs, and CRNAs, and authorizes APRNs to work in collaborative relationships with physicians. R&R specific to this law have not been written. Connecticut law defines collaboration as a mutually agreed upon relationship between an APRN and a physician who is educated, trained, or has experience related to an APRN's work. Current law exempts CRNAs because their service is under the direction of a licensed physician. SOP for APRNs is defined in statute; however, CNM SOP is recognized under separate statute. The NPA 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 master's degree in nursing or other related field and national board certification are required to enter into practice.

Reimbursement

Medicaid regulations govern reimbursement to APRNs under the remaining Medicaid fee-for-service programs. NPs, psychiatric CNSs, and CNMs are reimbursed for services under state insurance statutes, which affect only private insurers. Reimbursable services must be within the individual's 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

APRNs working in a collaborative relationship with a physician may prescribe, dispense, and administer medications, including Schedule II–V controlled substances that are expressly specified in the written collaborative agreement. If the APRN prescribes non-controlled substances only, state-controlled substance registration or a federal DEA number is not required. If the APRN prescribes controlled substances in a hospital setting only and the hospital has granted subscript authority under the hospital DEA number, a state-controlled substance registration number is required but a federal DEA number is not. If the APRN prescribes controlled substances in any other setting, the state-controlled substance registration and the federal DEA number are required. CRNAs can only administer drugs during surgery when the physician, who is medically directing the prescriptive activity, is physically present in the institution, clinic, or other setting. APRNs are legally authorized to request, receive, and dispense pharmaceutical samples.

Delaware

http://professionallicensing.state.de.us/boards/nursing/

http://www.delapn.org/links.php

✪ 2007 Legislative Activity

APNs opposed HB 106, relating to certified professional midwives (CPMs), creating licensure for CPMs. APNs, the medical society, the BON, and others opposed the elimination of the collaborative agreement currently required by rules and regulations.

Starting in July 2007, all new licensees for nursing now require criminal background checks.

Legal Authority

The Delaware BON regulates APNs and grants APN authority to practice. APNs are defined as NPs, CNSs, CNMs, and CRNAs. If the APN's SOP does not include independent acts of diagnosis or prescribing, practice authority is governed solely by the BON. If the APN wishes to provide independent acts of diagnosis or prescribing, the APN must apply to the JPC (composed of APNs, MDs, a pharmacist, and one public member). The JPC is statutorily empowered, with BOMP approval, to grant independent practice and/or prescriptive authority to nurses who qualify. APNs must practice in a collaboratory relationship with physicians while performing theses services. The collaborative agreement is a written document that outlines the process for consultation or referral complementary to the APN's independent practice area. The collaborative agreement is defined as "a true collegial agreement between two parties where mutual goal-setting access, authority, and responsibility for actions belong to individual parties and there is a conviction to the belief that this collaborative agreement will con-

tinue to enhance patient outcomes, and a written document that outlines the process for consultation and referral between an APN and physician licensed in Delaware, dentist, podiatrist, or licensed health care delivery system." If the agreement is with a licensed healthcare delivery system, the document must clarify that the system will supply appropriate medical back-up for purposes of consultation and referral. Requirements for physician supervision, chart review, or on-site physician visits do not exist. APN applicants must have a master's degree or post-basic certificate in a clinical nursing specialty, be nationally certified, submit a copy of their collaborative agreement, and show evidence of BON-specified relevant courses including advanced health assessment, diagnosis and management of problems within the clinical specialty, advanced pathophysiology and advanced pharmacology. If the APN has graduated from an approved program more than 2 years prior to application, the APN must document the equivalent of at least 30 hours continuing education in pharmacology and other areas.

Reimbursement

Delaware has statutory provisions requiring health insurers, health service corporations, and 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; some providers are recognizing APNs on managed care provider panels. CNMs have legislative authority under the Board of Health for third-party reimbursement. FNPs and PNPs also receive Medicaid reimbursement at 100% of physician payment.

Prescriptive Authority

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

District of Columbia

http://dchealth.dc.gov/prof_license/services/app_main_action.asp?strAppId=11

Legal Authority

The Washington, D.C. Department of Health BON approves and regulates APNs. APNs are defined as APRNs or CNPs, CNMs, CRNAs, and CNSs. Current law authorizes APNs to practice independently without a physician collaborative agreement or protocols. CNP SOP is defined in statute, regulated by the BON, and without limitations. APNs may apply for admitting privileges to the hospital. Graduation from a post-basic NP program or national certification in a specialty area is required to enter into practice.

Reimbursement

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

Prescriptive Authority

The D.C. regulations provide for full prescriptive authority including Schedules II-V controlled substances. The law and R&R authorize prescribing Schedules II-V controlled substances and allow dispensing of all medications, including sample medication. APNs are authorized to request and receive pharmaceutical samples. The D.C. Pharmacy Board issues DEA number to providers with controlled substance authority. Prescriptions are labeled with the APN name.

Florida

http://www.doh.state.fl.us/mqa/

2007 Legislative Activity

Although no legislative or regulatory action occurred in 2007, plans are in motion to recognize clinical nurse specialists as ARNPs.

Legal Authority

The BON certifies and regulates ARNPs, who are defined as NPs, CNMs, and CRNAs. ARNP SOP is defined in statute and includes the performance of medical acts of diagnosis, treatment, and operation pursuant to protocols established between the ARNP and physician, DO, or dentist. Within the framework of established protocols, ARNPs may order diagnostic tests and physical and occupational therapy. The degree and method of supervision, determined by the ARNP and physician, 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 yearly, and 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; on-site presence of the supervising practitioner is not required. ARNPs are not statutorily recognized as PCPs. ARNPs are authorized to admit patients to the hospital and hold hospital privileges; however, this authority is dependent upon privileges granted by the institution. ARNP applicants must have a master's degree to qualify for initial certification and are required to hold national board certification to enter practice.

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 80% of the physician rate if the physician is not on-site and does not countersign. Managed care companies are prohibited from discriminating against the reimbursement of ARNPs if based on licensure. Private insurers must reimburse CNM services if the policy includes pregnancy care.

Prescriptive Authority

The BON/BOM joint committee allows prescriptive privileges for ARNPs; however, controlled substances are excluded. ARNPs prescribe under 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 prescribers name on the drug label. ARNPs who dispense (distribute medication for reimbursement) must apply for dispensing privileges. ARNPs are authorized to request, receive, and/or dispense pharmaceutical samples.

Georgia

http://www.sos.state.ga.us/plb/rn/
http://www.georgianurses.org/

2007 Legislative Activity

Senate Bill 222 was passed and signed into law.This bill does not require CRNAs who graduated from an approved nurse anesthetist educational program prior to January 1, 1999 to hold a master's degree or other graduate degree.

Legal Authority

APRNs are authorized to practice and regulated by the BON. APRNs are defined as NPs, CNMs, CRNAs, and CNSs in psychiatric/mental health. APRN practice is collaboratory in nature. 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 au-

thority to the nurse to perform certain medical acts and provides for immediate consultation with the delegating physician under OCGA 43-34-26. APRNs may hold hospital privileges in limited situations, according to the Georgia Nurses Association. A master's degree or higher in nursing or other related field and national board certification is required for all APRNs at entry into practice except for CRNAs educated prior to 1999.

Reimbursement

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

Prescriptive Authority

APRNs practice under protocol as defined by O.C.G.A 43-34-26. A process exists that permits RNs (including APRNs) to administer, order, or dispense drugs under delegated medical authority, either as prescribed by a physician or as authorized by protocol. BON regulations governing protocols used by RNs require that the RN document preparation and performance specific to each medical act. "Medication orders" may be called into a pharmacy. APRNs are authorized to request and receive pharmaceutical samples.

Hawaii

http://www.hawaii.gov/dcca/areas/pvl/boards/nursing

Legal Authority

The BON grants authority and regulates APRNs in Hawaii. APRNs are defined in the NPA as an NP, CNS, CNM, or CRNA. Hawaii does not legally require a collaboratory or supervisory practice with a physician, with the exception of prescribing medications. A collegial working relationship with a physician is required for prescribing prescription medications, and a supervisory relationship with a physician is required for prescribing controlled substances. According to the BON, APRNs are considered independent providers. The APRN's SOP is defined in regulation (administrative rules). Hawaiian law does not specifically authorize APRNs to admit patients to the hospital or hold hospital privileges. The minimum requirements to enter practice in Hawaii are a master's in nursing and national certification in the APRN's clinical specialty.

Reimbursement

Current law provides direct reimbursement to all APRNs; however, APRNs are not legally recognized as PCPs. According to Hawaiian authorities, several insurance companies credential APRNs for their provider panels. Some APRNs are listed on managed care panels and are directly reimbursed for services. The reimbursement rate ranges from 85% to 100%. NPs and CNSs are also reimbursed through CHAMPUS. Medicaid expanded the types of APRNs they reimburse to include psychiatric CNSs and additional specialties of NPs. Medicaid reimburses at 75% of physician payment. Hawaii Health QUEST, a Medicaid waiver program, defines PNPs, FNPs, and CNMs as PCPs. However, QUEST, unlike Medicaid, does not require the QUEST healthcare plans to include APRNs as PCPs on their provider panels.

Prescriptive Authority

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

Idaho

www2.state.id.us/ibn/ibnhome.htm

Legal Authority

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

Reimbursement

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

Prescriptive Authority

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

Illinois

http://www.ildpr.com

Legal Authority

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

degree in their APN specialty or a graduate degree in nursing and a certificate from a graduate level program in one of the APN specialty areas. Additionally, APNs must hold national certification to enter into practice.

Reimbursement

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

Prescriptive Authority

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

Indiana

http://www.in.gov/pla/bandc/isbn/
http://www.indiananurses.org

2007 Legislative & Regulatory Activity

Legislative successes include the passage of the following:

PL 184: Permits advanced practice nurses to the list of professionals who may certify an individual as being severely restricted in mobility for purposes of issuance of a parking placard for a person with physical disabilities.

PL 197: Provides that: (1) an OT may not provide certain services unless the patient has been referred by specified providers [includes APN], and Removes: (1) the psychology board's authority to establish a list of restricted psychology tests.

PL 193: Establishes the prenatal substance abuse commission to develop a plan to improve early intervention and treatment for pregnant women who abuse alcohol or drugs or use tobacco. A designated seat is for an APN with a collaborative agreement.

Legal Authority

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

Reimbursement

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

Prescriptive Authority

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

Iowa

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

2007 Legislative Activity

Legislation is pending to modify code language which will authorize APNs to sign mental health and substance abuse evaluations, court reports, and driver's license restoration of privileges.

Legal Authority

The Iowa BON grants ARNPs authority to practice and regulates their practice through administrative rules. ARNPs are defined as NPs, CRNAs, CNMs, and CNSs. ARNPs are authorized to practice independently within their recognized nursing specialties, and collaborative practice agreements are not required by the BON. Scope of practice 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 a RN and certification by a national certifying body. A master's degree in nursing is only required for clinical nurse specialists.

Reimbursement

Iowa's Medicaid managed care and prepaid service programs reimburse ARNPs pursuant to legislation passed in 2003. 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. Managed care organizations are not mandated to offer ARNP coverage unless there is a contract or other agreement to provide the service. Under 2003 legislation, all 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 Schedule II-V controlled substance medications. ARNPs may prescribe, deliver, distribute, or dispense noncontrolled and controlled drugs, devices, and medical gasses, including pharmaceutical samples. ARNPs must register with the DEA, and prescriptions written by ARNPs must be labeled with their name.

Kansas

http://www.ksbn.org

✪ 2007 Legislative Activity

Minor changes in regulations related to ARNP education programs; several regulatory changes pending.

Legal Authority

The Kansas BON regulates the practice of ARNPs. The BON grants ARNP authority to practice and defines them as NPs, nurse midwives (NMWs), NAs, and CNSs. ARNPs function in collaboratory relationships with physicians and other healthcare professionals in the delivery of primary healthcare services. ARNPs 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 ARNP. SOP is defined in statute and regulation; however, ARNPs 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. New ARNP applicants in all categories, except NMWs, require a master's degree or higher in nursing; however, national board certification is not required to enter practice in Kansas.

Reimbursement

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

Prescriptive Authority

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

Kentucky

http://kbn.ky.gov
http://www.kcnpnm.org

✪ 2007 Legislative Activity

Regulation 201 KAR 20:059 went into effect March 2007 which places additional limitations on AP prescribing of controlled substances. Limitations include a 14-day supply of lorazepam, clonazepam, diazepam, alprazolam, and combination hydrocodone products in liquid and solid forms without refills, and a 30-day supply of carisoprodol without refills.

Legal Authority

The Kentucky BON grants ARNPs authority to practice and regulates their practice. ARNPs are statutorily defined as NPs, CNSs, CNMs, and CRNAs. ARNPs practice in collaboration with a physician in Kentucky for prescriptive purposes only. ARNPs may practice autonomously within their relative scopes of practice; however, they must practice in accordance with the scope of practice (SOP) of the national certifying organization as adopted by the BON in regulation. NP SOP is defined in Kentucky statute, KRS 314.011. "ARNPs shall seek consultation or referral in situations outside their scope of practice." ARNPs are recognized as "primary care providers" in regulation, and are legally authorized to admit patients to a hospital and hold hospital privileges; however, hospital regulations permit medical staff to set conditions. A master's degree in nursing and national board certification is required to enter practice in Kentucky.

Reimbursement

The state medical assistance program reimburses ARNPs for services at 75% of 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 United States 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 (including Medicaid programs).

Prescriptive Authority

ARNPs may prescribe scheduled II-V controlled substances and non-scheduled legend drugs pursuant to separate "Collaborative Agreement for Prescriptive Authority for Non-Scheduled Drugs (CAPA-NS)," and "Collaborative Agreement for Prescriptive Authority for Controlled Substances (CAPA-CS). The CAPA-CS and NS defines ARNP scope of prescribing authority and is signed by the ARNP and physician. ARNPs may prescribe CS II medications for a 72-hour supply with additional authority for psych/mental health clinicians. CS III medications for a 30-day supply have the following limitations: ARNPs may prescribe a 14-day supply of benzodiazepines and hydrocodone combination products without refills. ARNPs are still able to prescribe a 30-day supply of carisoprodol (Soma) without refills. Other schedules IV and V may be prescribed with refills not to exceed a 6-month supply. CRNAs do not need CAPAs to deliver anesthesia care. The ARNP alone signs his or her name to the prescription pad when prescribing. ARNPs must complete 5 contact hours in Rx annually as part of their CE requirement. ARNPs are legally authorized to request and receive drug samples (non-controlled legend medications only) and may dispense pharmaceutical samples. Dispensing is applicable to ARNPs working in health departments: ARNPs may dispense with a written agreement with a local pharmacist.

Louisiana

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

Legal Authority

APRNs are licensed by the BON and are defined as NPs, CNMs, CRNAs or RNAs, and CNSs. APRNs perform certain acts of medical diagnosis in accordance with a "collaborative practice agreement," a formal written statement addressing the parameters of the collaborative practice which are mutually agreed upon by the APRN and physician(s) or dentist(s) including consultation or referral availability, clinical practice guidelines, and patient coverage. APRNs' SOP is limited to their BON-recognized category and area of specialization. The APRN SOP includes "certain acts of medical diagnosis or medical prescriptions of a therapeutic or corrective nature, prescribing assessment studies, legend and certain controlled drugs, therapeutic regimens, medical devices and appliances, receiving and distributing a therapeutic regimen of prepackaged drugs prepared and labeled by a pharmacist, and free samples supplied by a drug manufacturer." Louisiana State law includes "Any Willing Provider" language pursuant to the passage of SB 135/Act 106, 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

The passage of SB 135/Act #106 in 2006 provides that any qualified plan shall not exclude direct reimbursement of healthcare services provided by an APRN as stated above. Medicaid Managed Care is required to reimburse FNPs and PNPs at a rate equal to that of physicians per-

forming the same service. Medicaid recognizes FNPs and PNPs as primary care case managers/providers and will give assignment of NPs as the PCP or "Medical Home" under certain circumstances. APRN's are reimbursed at 80% of physician fees per Medicaid; all billing must be under the APRN license, essentially eliminating "incident to" billing.

Prescriptive Authority

APRN's have prescriptive authority in Louisiana, including Schedules II-V controlled substances. The BON has sole authority to develop, adapt, and revise R&R governing SOP, including Rx authority, the receipt and distribution of sample and prepackaged drugs, and prescribing of legend and 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 served by the collaborative practice has an identified need. Prescribing distributed controlled substances (Schedules II-V) must be consistent with the practice specialty of the collaborating physician and the APRN's licensed category and area of specialization. APRN's with authority to prescribe or distribute controlled substances may not prescribe controlled substances to treat chronic or intractable pain or obesity, or themselves or family.

Maine

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

Legal Authority

The Maine BON authorizes and regulates APRN practice. APRNs approved by the BON are defined as CNPs, CNMs, CNSs, and CRNAs. A CNP who qualifies as an APRN must practice for at least 24 months under the supervision of a licensed physician or must be employed by a clinic or hospital that has a medical director who is a licensed physician. The CNP must submit written evidence to the BON upon completion of the required clinical experience." After this 24-month period, the CNP can practice independently. CNSs practice independently. CRNAs are responsible and accountable to a physician or dentist. The APRN 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". CNPs and certified psychiatric CNSs may sign documents for emergency involuntary commitment through emergency departments. 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 (licensed after January 1, 2006) 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 identification numbers to CNPs and CNMs; and allows managed care enrollees to designate CNPs as their PCP. However, managed care organizations are not required to credential any physician or CNP if their "access standards" have been met. Reimbursement under indemnity plans is mandated for master's-prepared, certified psychiatric/mental health CNSs; no other third-party reimbursement for APRNs is required by law. Some insurance carriers, however, reimburse independent CNPs. Medicaid reimburses in full, on a fee-for-service basis, for services provided by certified family nurse practitioners, 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 in independent practice and CNMs may prescribe Schedule II-V controlled substances and drugs off-label, according to common and established standards of practice. Dependency on other professionals for APRN prescriptive authority does not exist, except in the case of CNPs working pursuant to medical delegation by a physician (an employment practice required by a number of Maine hospitals). CNPs working pursuant to medical delegation may now prescribe controlled substance II medications after written request to the BoLM and their approval. APRNs may receive and distribute drug samples included in the formulary for Rx writing.

Maryland

http://www.mbon.org

✪ 2007 Legislative Activity

SB 378 and HB 445 have been signed by the Governor requiring that the State Board of Nursing consist of one member certified in an advanced practice nursing specialty.

Regulations pertaining to CRNAs are pending. These require all CRNA graduates after January 2008 to hold a minimum of a master's degree.

Legal Authority

The Maryland Board of Nursing and Board of Medicine jointly regulate APN practice. APNs are defined as NPs, Certified Registered Nurse Anesthetists (CRNAs), CRNMs, and APRNs/Psychiatric Mental Health Nurses. APNs are legally required to have a written agreement with a collaborating physician, which must be approved by an equally represented physician and NP joint committee. Once the agreement is approved, NPs may perform the functions of the agreement independently. NP SOP is defined in regulation. Current law recognizes APNs as "PCPs". The minimum degree required to enter practice in the State of Maryland is an associate degree; however, national board certification is required.

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 a managed care organization; NPs (with the exception of neonatal and acute care) and CRNMs 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; APNs are not to be arbitrarily denied. Legislation passed in 2003 requires an HMO to permit an enrollee to select a certified NP as the enrollee's PCP if (1) the NP provides services at the same location as the NP's collaborating MD and (2) the collaborating MD provides the continuing medical management required. The law does not require that an HMO include NPs on the HMO panel as PCPs. The state NP association signed an agreement letter with the state medical society that neither will bring this issue back to the legislature for 5 years.

Prescriptive Authority

NPs and CNMs have full prescriptive authority, including schedule II-V controlled substances. The scope of prescriptive authority is defined by the written agreement developed by the NP and collaborating physician. CNMs have statutory authority to prescribe based on a formulary mutually developed by the BON, BOM, and BOP. NPs and CNMs are authorized to obtain both federal and state DEA numbers. The Division of Drug Control lists newly authorized NP and CNM prescribers in their newsletter and sends a list of authorized NP and CNM prescribers to pharmacists. NPs and CNMs are legally allowed in most settings (those in which drug samples are state authorized to be distributed) to dispense medications. Prescription containers are labeled with the NP or CNM name.

Massachusetts

http://www.state.ma.us/reg/boards/rn/
http://www.mcnpweb.org

✪ 2007 Legislative Activity

S. 1226: A bill requiring health insurers to list NP's as Primary Care Providers on their panel. This

bill is sponsored by Massachusetts Coalition of Nurse Practitioners MCNP.

S. 1236, filed by a group of midwives and nurse anesthetists seeking removal of the supervisory language in the Nurse Practice Act.

Legal Authority

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

Reimbursement

FNPs, PNPs, and adult nurse practitioners are reimbursed at 100% of physician payment rate for Medicaid unless the NP is employed by the hospital in a hospital-based practice. Massachusetts state law mandates reimbursement to NPs, PCs, CNMs, and NAs In accordance with Chapter 302 of the Acts and Resolves of 1994. These include indemnity plans, 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. An HMO protection statute allows "other providers" to be listed on panels; however, the law does not specifically address APNs or require them to be listed as providers.

Prescriptive Authority

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

Michigan

http://www.michigan.gov/mdch/0,1607,7-132-27417_27529_27542—-,00.html
http://www.micnp.org/

Legal Authority

The BON authorizes advanced practice authority as a specialty certification. Nurse specialists are defined as CNMs, CRNAs, NPs. Nurse specialists are not required to have physician collaboration or supervision, with the exception of prescriptive authority. Scope of practice is defined in statute, and 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, according to the state nursing association, this depends on the institution, but hospitals generally grant these privileges. Nurse specialists are required to have a master's degree in nursing and national board certification to enter into practice.

Reimbursement

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

Prescriptive Authority

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

Minnesota

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

✪ 2007 Legislative Activity

SF 26: Amendment regarding examination for individuals operating X-ray equipment but provides an exemption from the exam for certain healthcare practitioners, including CRNAs.

SF 26: Defines electronic transmission prescription requirements and indicates that "dispense as written" must be specifically designated, cannot be default

Legal Authority

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

Reimbursement

APRNs may enroll with Medicaid as a provider and bill for services. FNPs, PNPs, GNPs, WHNPs, and ANPs are reimbursed by Medicaid at 90% of the physician rate. CNPs, CNMs, CRNAs, and CNSs in psychiatric health have legal authority for private insurance reimbursement. Minnesota law prohibits HMOs and private in-

surers from requiring a physician's co-signature when an APRN orders a laboratory test, X-ray, or diagnostic test.

Prescriptive Authority

APRNs who meet statutory requirements may prescribe, receive, dispense, and administer drugs including controlled substances Schedules II-V within the scope of their written agreement with a physician and within the practice specialty. CNPs, CRNAs, and CNSs must have a written agreement with a physician that defines the delegated responsibilities related to prescribing drugs and devices. CNMs have independent Rx authority. The BON does not grant prescriptive authority; however, they do have the authority to discipline the APRN if the prescribing practices are unsafe, unethical, or illegal. An authorized APRN who chooses to prescribe controlled substances must apply to the DEA and verify compliance with Minnesota prescribing laws with the BON. APRNs have statutory authority to receive and dispense sample drugs within their authorized scope of practice.

Mississippi

http://www.msbn.state.ms.us
http://www.msnurses.org

Legal Authority

The Mississippi BON grants APNs authority to practice and regulates their practice. APNs are defined as NPs, CRNAs, and CNMs and CNSs. The R&Rs are jointly promulgated by the BON and BOM, and implemented by the BON. CNSs have title protection. NPs, CRNAs, and CNMs practice in a collaborative relationship with physicians in Mississippi. The collaborating physicians' practice must be compatible with the NP's practice. NPs must practice according to a BON-approved protocol agreed on by the NP and physician. NP applicants must submit official evidence of graduation from a graduate program with a concentration in the applicant's APN specialty. 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 in rules and regulations. NPs are statutorily recognized as "PCPs", however, Mississippi law does not contain "any willing provider" language. APNs are legally authorized to admit patients and hold hospital privileges. APNs are required to have a master's degree in nursing and be nationally certified to enter into practice.

Reimbursement

Medicaid reimbursement is available to APNs at 90% of 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 a NP working under the supervision of a physician, the insured shall be entitled to reimbursement whether the services are performed by the physician or NP.

Prescriptive Authority

NPs have full prescriptive authority, including Schedule II-V controlled substances, based on the standards and guidelines of the NP's national certification organization and a BON-approved protocol that has been mutually agreed on by the NP and qualified physician. The protocol must outline diagnostic and therapeutic procedures and categories of pharmaceutical agents that may be ordered, administered, dispensed and/or prescribed for patients with diagnoses identified by the NP. NPs 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

http://pr.mo.gov/nursing.asp

Legal Authority

The Missouri BON grants APRNs authority to practice and regulates their practice. APRNs are defined as NPs, CNSs, CNMs, and CRNAs. APRNs practice in collaboration with physicians in Missouri. Collaborative practice includes written agreements, written protocols, or written standing orders. Rules and Regulations define the Collaborative Practice Rule (CP). Three focus areas in the CP rule include: (1) geographic areas to be covered, (2) methods of treatment that may be covered by CP arrangements, and (3) requirements for review of services provided pursuant to a CP arrangement. A written CP arrangement with a physician is not needed when the APN is performing nursing acts consistent with the 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 or anesthesiologist. Individuals are recognized by their specific clinical nursing specialty area as a CNS, NP, NM, or CRNA, which delineates their title and SOP as APRNs in rules and regulations. 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 master's 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 APN, 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 and/or rural healthcare facility. Medicaid reimbursement is limited to services furnished by enrolled APRNs who are within the SOP allowed by federal and state laws and inpatient or outpatient hospital services or clinic services furnished to the extent 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 APRNs is limited to prescription drugs and devices without controlled substances as delegated by a physician pursuant to a written CP arrangement. Delivery of such APRN healthcare services shall be within the APRN's advanced clinical nursing specialty area and a mutual SOP with the physician, and be consistent with the individual's skill, training, education, and competence. APRNs may receive/dispense samples within their Rx authority. In certain instances, a state BNDD number is required. Prescriptions written by a NP are labeled with both the collaborating physician's and NP's name.

Montana

http://www.nurse.mt.gov

2007 Legislative Activity

HB 496 has been signed into law authorizing ARNPs and PAs to complete medical examinations pertaining to traffic laws.

HB 497 has been signed into law and states that certification of a person as disabled for purposes of obtaining a permit to hunt from a vehicle may be endorsed by an APRN or PA.

Legal Authority

The Montana BON grants APRNs authority to practice and regulates their practice. APRNs are defined as NPs, CNSs, CNMs, and CRNAs. APRNs practice independently after completion of specific curriculum requirements and a national certifying examination 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. NP SOP is defined in

Rule ARM 8.32.301, and NPs are statutorily recognized as "PCPs." Montana state law, however, does not contain "any willing provider" language. APNs are legally authorized to admit patients and hold hospital privileges; however, this varies according to the rules and bylaws of each hospital. APRNs must have a master's degree in nursing and hold national certification to enter into practice. All APRNs must achieve mandatory continuing education hours for renewal every 2 years.

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 through the recommendation of the Prescriptive Authority Committee, consisting of BON members. APRNs with Rx authority are authorized to prescribe all medications, including Schedules II-V controlled substances using their own DEA number, and are permitted to receive and dispense drug samples. Authority to prescribe is not dependent on any other health professional. Prescribing APRNs must have a quality-assurance program in place, with a defined process of referral. The quality assurance method must be BON-approved before issuance of prescriptive authority and includes 15 charts or 5% of all APRN charts reviewed quarterly by an APRN or physician in the same specialty. Additional continuing education for prescriptive authority (additional to CE requirement for practice authority) is required for renewal every 2 years.

Nebraska

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

2007 Legislative Activity

LB 256 passed the Nebraska State Legislature in 2005 and became effective July 1, 2007. This "umbrella" legislation defines APRN to include NPs, CRNAs, CNMs, and CNSs. It also provides for the licensure of CNSs. A new APRN Board became effective on July 1, 2007.

Legal Authority

The Nebraska APRN Board grants APRNs authority to practice and regulates their practice. APRNs are defined as NPs, CRNAs, CNMs, and CNSs. 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, "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 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 was not reported in the survey. NPs without a master's or doctoral degree, and/or at least 2,000 hours of physician-supervised practice must also have jointly approved protocols. NPs licensed after 1996 must have a master's or doctoral degree to practice July 1, 2007, an NP in women's health and neonatal practice will also be required to have a masters or doctoral degree. 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. Medicaid reimburses NPs at 100% of physician payment.

Prescriptive Authority

Nebraska NPs are authorized full prescriptive authority including Schedules II-V medications, as defined in their statute. July 14, 2006 the limitation of prescribing Schedule II controlled substance for pain control only up to 72 hours, was removed. NPs may request, receive, and dispense pharmaceutical samples if the samples are drugs within their prescribing authority. CRNAs prescribe within their specialty practice; authority is implied in the statute. Qualified CRNAs, NPs, and CNMs may receive DEA numbers.

Nevada

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

Legal Authority

The Nevada BON grants APNs authority to practice and regulates their practice. To qualify for APN certification, an application must have completed an education program to prepare an APN (NP, CNS, CNW, nurse psychotherapist). If the applicant completed an APN program before July 1, 1992, the applicant must have worked 800 hours in APN practice during the 5 years immediately preceding the application and must have an active certification/license in another state or jurisdiction. If the applicant completed an APN program between July 1, 1992 and June 1, 2005, the applicant must hold a current national certification as an advanced practitioner of nursing OR hold a bachelor's degree in nursing from an accredited school AND must have worked 800 hours in APN practice during the 5 years immediately preceding the application OR have completed a program designed to prepare an advanced practitioner of nursing in the preceding 2 years. If the applicant completed an APN program after June 1, 2005, the applicant must hold a master's degree in nursing or related health field. APNs in Nevada practice in collaboration with a physician. The APN must keep written protocols at every job site, together with a collaborative agreement signed by a BOME-approved physician. APN SOP is defined in regulation and includes performance of "designated acts of medical diagnosis, prescribe therapeutic or corrective measures, and prescribe controlled substances, poisons, dangerous drugs and devices." APNs are not recognized as "PCPs" under state law; however, APNs are legally authorized to admit patients to the hospital and hold hospital privileges.

Reimbursement

APNs 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 APNs at 85% of physician reimbursement.

Prescriptive Authority

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

New Hampshire

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

2007 Legislative Activity

HB 345, relative to certification of death certificates. Effective immediately, NH-licensed ARNPs have statutory authority to certify a NH

death record. As of January 1, 2008, all death records must be certified electronically to the NH Department of Vital Statistics.

HB 673, allowing ARNPs to certify walking disabilities. Effective August 17, 2007, NH-licensed ARNPs will have statutory authority to certify for walking disability plates and placards to the NH Department of Motor Vehicles.

NUR 302.04(a)(4): The NH BON undertook an extensive revision of the rules in 2006/07. Among the changes was a reduction in the number of specialty categories (4) to which an ARNP may be licensed: Adult; Pediatric, CRNA and CNM. In addition, one fee will now cover one or more categories.

Legal Authority

The New Hampshire BON grants ARNPs authority to practice and regulates their practice. Regulatory changes now recognize adult and PNPs, CRNAs, and CNMs. ARNPs do not require physician collaboration or supervision. ARNP SOP is defined in statute. ARNPs are statutorily recognized as "PCPs" in NH; however, state law does not include "any willing provider" language. ARNPs 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 ARNPs when the insurance policy provides for any service that may be legally performed by the ARNP and such service is rendered. ARNPs are recognized as PCPs by several HMOs in the state. Medicaid reimburses ARNPs at 100% of physician payment.

Prescriptive Authority

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

New Jersey

http://www.state.nj.us/lps/ca/medical.htm
http://www.njsna.org

Legal Authority

The New Jersey BON grants APNs authority to practice and regulates their practice. APNs are defined as NPs and CNSs. APNs practice in collaboration with physicians and are required to have a Joint Protocol with the collaborating physician for prescribing purposes 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; however, this is not defined by statute or regulation. Privileges are determined through the credentialing/privileging process of individual healthcare institutions. APN applicants must be 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 credential APNs as "PCPs," but are not required to recognize or reimburse them. Medicaid fee-for-service programs reimburse APNs at approximately 85% of the physician rate, but the rate may vary according to procedure and setting. BC/BS must reimburse APNs directly if the reimbursed service can be performed within the APN's SOP and the APN is not an employee of a physician or an institution. The state health benefits plan covering all public employees directly pays some APNs.

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 purposes only and is not a collaborative agreement for general practice. APNs must apply for both a state controlled dangerous substance number and a federal DEA number. APNs are authorized to request, receive, and dispense pharmaceutical samples.

New Mexico

http://www.state.nm.us/nursing
http://www.nmnpc.org

Legal Authority

The New Mexico BON grants APRNs authority to practice and regulates their practice. APRNs are defined as CNP, CRNA, and a CNS. 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. A master's degree in nursing or higher and national board certification is required to enter into practice as a CNP. The BON also regulates CRNAs and CNSs. CRNAs seeking initial licensure must be at the master's level or higher. CRNAs work in collaboration with a physician and have Rx authority including Schedules II-V controlled substances. CNSs must be master's prepared and certified by a national certifying nursing organization. CNSs "make independent decisions"; have "prescriptive authority," including Schedules II-V controlled substances; and can distribute prepackaged drugs. CNMs are regulated by the Department of Health. CNPs can serve as "acute, chronic, long-term, and end-of-life health care providers."

Reimbursement

Statutory authority for third-party reimbursement for NPs and 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. FNPs and PNPs receive Medicaid reimbursement at 85% of physician payment. All three of the managed care groups contracted to provide Medicaid coverage have contracts with NPs.

Prescriptive Authority

CNPs have full, independent prescriptive authority, including Schedules II-V controlled substances. BON prerequisites to prescribe controlled substances include experience with Rx writing, a state-controlled substance license, and a DEA number. Each CNP must maintain a formulary. CNSs must have graduate-level pharmacology, pathophysiology, a physical assessment course, and prescribe in collaboration with a physician, CNP, or CNS with Rx authority during a 400-hour preceptorship before they can prescribe independently. CNMs have Rx authority; the Department of Health has rule-making authority. CRNAs who meet prescriptive authority requirements may collaborate independently and prescribe and administer therapeutic measures, including dangerous drugs and controlled substances within emergency procedures, 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 CNP name, where appropriate.

New York

http://www.op.nysed.gov/nurse.htm
http://www.thenpa.org/
http://www.nysna.org

2007 Legislative Activity

Many of The NPA's sponsored and supported bills did advance but ultimately were negatively impacted by the end-of-session breakdown of

the legislative process this year. Several bills passed either the Senate or Assembly but not both houses. The following is a list of The NPA sponsored and supported bills and their status at the end of the 2007 Regular Legislative Session:

S.599-A (Hannon)/A.7074-A (John): NP Authorization to Sign Death Certificates passed the Senate but remained in the Assembly Rules Committee.

S.3094 (Volker)/A.5477 (Gottfried): NP Reimbursement Assurance Act, which would have assured health plans do not deny reimbursement for services provided by NPs acting within their lawful scope of practice. This bill remained in the Insurance Committee in both houses.

S.598 (Hannon)/A.8162 (Gottfried): NP Do Not Resuscitate Orders passed the Assembly, but remained in the Heath Committee in the Senate.

S.3093 (Volker)/A.6342 (Gottfried): NP Reimbursement Bill, Ensures that health plans that provide reimbursement to subscribers for certain physician services not exclude licensed and certified nurse practitioners from their primary care and specialty provider networks and must provide reasonable reimbursement to subscribers who choose to receive such services from a nurse practitioner. This bill passed the Assembly, but remained in the Heath Committee in the Senate.

S.1631-A (Maziarz)/A.5847-A(John) NP Workers Compensation, was moved by the Senate Labor Committee to the Senate Rules Committee, and remained in the Assembly Labor Committee.

S.5098 (Trunzo)/A.8430 (Morelle) NP Distinctive License Plate, authorizes a distinctive license plate for members of the Nurse Practitioner Association New York State. This bill was moved by the Senate Transportation Committee to the Senate Rules Committee, and remained in the Assembly Transportation Committee.

S.4647 (Hannon) /A.8392 (Gottfried): NP Immunization Bill authorizes nurse practitioners to certify that an immunization may be detrimental to a child's health. This legislation remained in the Senate Health Committee, and was advanced from the Assembly Health Committee to the Assembly Calendar.

Legal Authority

The New York State Education Department grants NPs authority to practice and regulates their practice pursuant to Title VIII, Article 139 of NYS Education Law. APNs are defined as NPs. NPs are licensed as RNs by the BON and certified by the State Education Department as NPs. NPs are legally required to practice in collaboration with physicians in accordance with a written practice agreement and written practice protocols. NP SOP is defined in statute. NPs are considered independent practitioners who are authorized to diagnose, treat, and prescribe in accordance with collaborative practice. The written agreement must include a provision for dispute resolution between the NP and the physician and provisions for a review by the collaborating physician of a patient record sample at least every 3 months. NPs are 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.

Reimbursement

NPs of all specialties may register as Medicaid providers and be reimbursed at 100% of the physician rate. 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."

Prescriptive Authority

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

North Carolina

http://www.ncbon.org

http://www.ncnurses.org/practice_npcouncil_home.html

Legal Authority

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

Reimbursement

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

Prescriptive Authority

NPs and CNMs have full prescriptive author-

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

North Dakota

http://www.ndbon.org

Legal Authority

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

Reimbursement

FNPs, PNPs, and CNMs, receive Medicaid reimbursement at 75% of the physician rate and CNMs at 85% of physician rate. BCBSND reimburses CRNAs, CNMs, CNSs, and NPs based on the lesser of the 1) provider's billed charges or, 2) 75% of the BC/BS physician payment system in effect at the time the services are rendered. 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 the following cities: Williston, Dickson, Minot, Bismark, Jamestown, Devils Lake, Grand Fords, Wahpeton, and Fargo shall be reimbursed the lesser of 1) provider's billed charges or, 2) 85% of the BCBSND physician payment system(s) in effect at the time services are rendered.

Prescriptive Authority

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

Ohio

http://www.nursing.ohio.gov

http://www.ohnurses.org/

✪ 2007 Legislative Activity

HB 253 (Rep. Oeslager): If passed, would enhance the APN's authority to prescribe Schedule II controlled substances.

HB 67 (Rep. Patton): Passed and allows APNs to authorize an individual to obtain a handicap designation on a motor vehicle.

Legal Authority

The Ohio BON grants APNs authority to practice and regulates their authority. APNs are defined as CNPs, CRNAs, CNMs, and CNSs. Legal authority to practice requires a collaborative practice arrangement between a physician and a CNP, CNM, or CNS. These groups of nurses (except Psych/Mental Health CNSs) must develop a standard care arrangement (practice agreement) with the collaborating physician. CRNAs are required to practice with a supervising physician. The SOP for CNPs is defined in statute, ORC 4723.43. APNs are statutorily recognized as providing "primary care services;" however, they are not currently authorized to admit patients or hold hospital privileges. Currently, CNPs, CNSs, and CNMs do not have statutory authority to admit patients or 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. Certification from a national certifying body is also required to enter into practice.

Reimbursement

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

Prescriptive Authority

Ohio state law grants full prescriptive authority to qualified CNPs, CNMs, and CNSs on a voluntary basis, which includes Schedules II-V controlled substances under the following rules and in collaboration with a physician. A separate approval process is required to apply for prescriptive authority. APNs prescribe based upon a formulary developed and approved by the Interdisciplinary Committee on Prescriptive Governance. The formulary lists (1) permitted drugs, (2) drugs excluded from use, (3) physician-initiated drugs that can be renewed or adjusted, and (4) drugs with special parameters. APNs are not permitted to prescribe newly released drugs until the Committee has reviewed them, and those who wish to prescribe drugs for off-label use must include parameters for off-label use in the standard care arrangement. Schedule II controlled substances are limited to the care of terminally ill patients after physician-initiation and only for a 24-hour period. DEA registration is required. Pharmacists log the prescription by nurse prescriber, not by a physician. The BOP and BON agree that the nurse with Rx authority may request, receive, sign for, and distribute sample medications within their scope and within the formulary. According to the law, (1) no fee may be charged for a sample, (2) only a 72-hour supply (or smallest commercially available size) may be dispensed, and (3) samples of controlled substances may not be dispensed.

Oklahoma

http://www.lsb.state.ok.us

http://www.ok.gov/nursing

✪ 2007 Legislative Activity

OAC 485:10 was revised: In Subchapter 15, the revisions in 485:10-15-5 clarified requirements for reinstatement and return to active of advanced practice recognition. In 485:10-15-6, the specialty category for School Nurse Advanced Practice Registered Nurse was deleted since this certification examination is no longer offered. In Subchapter 16, requirements for renewal, reinstatement, and return to active status for prescriptive authority were clarified.

Legal Authority

The Oklahoma BON grants APNs authority to practice and regulates their practice. APNs are defined as ARNPs, CNMs, CNSs, and CRNAs. ARNPs function independently with the exception of prescriptive authority, which requires supervision by a physician. APNs practice within a SOP as defined by the NPA. The SOP for an ARNP is defined in regulation and is further identified in specialty categories that delineate the population served such as adult ARNP, family ARNP, and so forth. ARNPs are listed as "primary care managers" in the Oklahoma Medicaid system. Authorization to admit patients or hold hos-

pital privileges was not reported in this survey. CNSs must hold a master's degree in nursing, and ARNPs and CNSs must be nationally board certified to enter into practice.

Reimbursement

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

Prescriptive Authority

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

Oregon

http://www.oregon.gov/OSBN
http://npo.oregonrn.org/

2007 Legislative Activity

HB 2247 passed, expanding and clarifying the ability of NPs to see workers' compensation patients and determine disability.

SB 717 was defeated. This bill would have created a SOP committee under the Board of Medical Examiners (later modified to provide for a nonregulatory institute) to evaluate scope of practice changes and challenges by health professionals. The primary opposition to the bill was articulated by naturopaths, midwives, NPs, and physical therapists.

Final approval of regulations adopted in 2006 was received by the DEA. This allows the Board to begin issuing prescriptive and dispensing authority to CNSs, including Schedule II-V medications.

Legal Authority

The Oregon BON grants APNs authority to practice and regulates their practice. APNs are defined as NPs (which includes CNMs), CNSs, and CRNAs. Nurses in all three categories of advanced practice must be credentialed with a certificate by the BON. APNs in Oregon are independent and are not required to have a collaboratory or supervisory relationship with a physician. SOP is defined in regulation, Division 50 of the Nurse Practice Act. Division 56 addresses prescriptive and dispensing authority for both NPs and CNSs. 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 and the NP or CRNA educated after specific dates (see regulations for further information); however, national board certification is not required to enter into practice in Oregon.

Reimbursement

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

Prescriptive Authority

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

Pennsylvania

http://www.dos.state.pa.us/nurse
http://www.pacnp.org

2007 Legislative Activity

On September 18, 2007, Act 48 of 2007, the amendment to the Professional Law, became effective. The law sets forth specific practices for CRNPs in PA and requires the CRNP to hold malpractice insurance. Also, on July 20, 2007, Act 49 of 2007 was signed into law. This act amends the Professional Nursing Law to provide official recognition of the CNS.

Legal Authority

The Pennsylvania BON grants CRNPs authority to practice and regulates their practice. A CRNP performs the expanded role in collaboration with a medical or osteopathic physician. Collaboration is defined as a process in which a CRNP works with one or more physicians to deliver healthcare services within the scope of the CRNP's expertise. The 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 PCP. 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 examination; CRNPs without a master's degree/certification are accepted if their CRNP was granted prior to the law's effective date. CNSs are not specifically defined or regulated beyond the RN SOP. The BON does not track, monitor, or license CRNAs. The BOM licenses and regulates CNMs.

Reimbursement

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

Prescriptive Authority

The BON confers prescriptive authority, including Schedules II-V controlled substances, to CRNPs with a collaborating physician. Regulations allow a CRNP to prescribe and dispense drugs if the CRNP has successfully completed a minimum of 45 hours of course work specific to advanced pharmacology and if the prescribing and dispensing is relevant to the CRNP's area of practice, documented in a collaborative agreement, and not from a prohibited drug category. The CRNP may write a prescription for a Sched-

ule II controlled substance for up to a 72-hour dose if the CRNP notifies the collaborating physician within 24 hours. CRNPs may prescribe Schedules III-V medications for up to a 30-day supply, however, the physician must authorize a refill. CRNPs are authorized to request, receive, and dispense pharmaceutical sample medications. Prescription blanks must include the name and certification number of the CRNP and identify the collaborating physician. The collaborative agreement is a signed, written agreement between the CRNP and a collaborating physician and must identify the parties to the agreement; area of practice; specify the categories of drugs from which the CRNP may prescribe and dispense; specify conditions for prescribing a Schedule II controlled substance; and specify the circumstances and how often the collaborating physician will personally see the patient, be kept at the primary practice site, and be available for inspection.

Rhode Island

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

2007 Legislative Activity

Global signature authority of CRNPs: Whenever any provision of the general or public law, or regulation requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, it shall be deemed to include a signature, certification, stamp, verification, affidavit or endorsement by a CRNP; provided, however, that nothing in this section shall be construed to expand the scope of practice of nurse practitioners passed in the last legislative session

Legal Authority

The Rhode Island BON grants APNs authority to practice and regulates their practice. APNs are defined as CRNPs, CRNAs, and Psychiatric and Mental Health Clinical Nurse Specialists (PCNSs). There are no requirements for physician collaboration to practice as a CRNP, with the exception of prescriptive authority. SOP is defined within the NPA. CRNPs are statutorily recognized as "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. The minimum degree to enter into practice is a master's degree in nursing and national board certification is required. CNMs have a separate law and separate R&R that are not under the BON. BON R&R define CNSs.

Reimbursement

State law allows for direct reimbursement of psychiatric CSs and CNMs. CRNPs 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 CRNPs and CNMs to serve as PCPs. CRNAs receive third-party reimbursement for services under the supervision of anesthesiologists or dentists.

Prescriptive Authority

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

South Carolina

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

http://www.scnurses.org/A_P_SIG/

2007 Legislative Activity

South Carolina had several issues brought to the legislature including the passage of a bill authorizing electronic prescribing, 90-day supply of controlled substance III-V. The BOM was defeated in their efforts to amend the Medical Practice Act to limit CRNAs with giving anesthesia in outpatient office based surgery and in their efforts to amend the Medical Practice Act that would have limited the title "Dr" just to physicians. All providers who hold a doctorate can be called "Dr." as long as they present their additional credentials. A bill was defeated that would authorize surgical technicians to obtain a license and recognition as first assistants. This bill was opposed because it would allow unlicensed and unqualified technicians to perform Nursing and APRN duties. Additionally, revisions to the Medical Act state a MD could not designate performance of licensed tasks through (like an APRN, RN) to be done by an unlicensed person like a Medical Office Assistant.

South Carolina APRNs were not successful in getting revisions to the NPA out of committee.

Legal Authority

The South Carolina BON grants APRNs authority to practice and regulates their practice. APRNs are defined as an NP, CNM, CNS, or CRNA. APRNs must have a collaboratory relationship with a physician and may perform "delegated medical acts" in addition to nursing acts as defined by the BON. "Delegated medical acts" may be performed by APRNs pursuant to an approved written protocol between the nurse and physician, and are defined as "additional acts delegated by the physician that include formulating a medical diagnosis and initiating, continuing, and modifying therapies, including prescribing drug therapy under approved written protocols." NPs who manage delegated medical aspects of care must have a supervising physician who can be accessed by electronic/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 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 22 payers recognize, enroll, and directly reimburse APRNs for services provided. Dr. Stephanie Burgess, 1st APRN to sit on the advisory board for State Health and Human Services Board in SC- rest of Board are MDs.

Prescriptive Authority

APRNs have prescriptive authority, including Schedule III-V controlled substances, and prescribe according to practice agreement/protocol within the specialty area of the APRN. The BOP has opined that, "The supervising physician is not the prescriber. The NP prescribes independently of the supervising physician, has their own DEA registration, and must have a state and federal ID number." The BON issues an 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.

South Dakota

http://www.state.sd.us/doh/nursing

Legal Authority

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

Reimbursement

CNPs and CNMs receive Medicaid reimbursement at 90% of the physician payment rate. CRNAs are reimbursed at the physician rate for services provided under Medicaid. State insurance law is silent regarding CNSs; however, CNSs may be reimbursed under specific plans. Medicaid reimbursement is allowed only if billed through a physician's practice. CNPs and CNMs receive third-party reimbursement. State law mandates that CRNAs, CNPs, and CNMs 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 controlled substances Schedules II-IV as authorized by the collaborating physician agreement. CNPs and CNMs have two controlled substance registration options: (1) they may seek independent state registration and independent DEA registration in all schedules as authorized by their collaborative agreement; or (2) they may act as an agent of an institution, using the institution's registration number to prescribe, provide, or administer controlled substances. Controlled substance authority is granted by separate application to the Department of Health following collaborative agreement approval by the BON and BOM. CNPs and CNMs may request and receive drug samples, provide drug samples, and provide a limited supply of labeled medications. Medications and sample drugs must be accompanied by written administration instructions and documentation entered in the patient's medical record. The provision of drug samples or a limited supply of medications is not restricted, with the exception of Schedule II controlled substances, which are limited to a one-time, 30-day supply. Therefore, the amount provided is at the professional discretion of the CNP or CNM and the collaborating physician. CNPs or CNMs who accept controlled substances, either trade packages or samples, must maintain a record of receipt and disposition. CRNAs and CNSs do not have Rx authority. CNSs may order and dispense durable medical equipment and therapeutic devices in collaboration with a physician.

Tennessee

http://www.tnaonline.org

http://www2.state.tn.us/health/Boards/Nursing/

Legal Authority

The Tennessee BON grants APNs authority to practice and regulates their practice. APNs are defined as NPs, CNMs, CRNAs, or CNSs. APNs meeting requirements for prescriptive authority are eligible for a certificate that is designated "with certificate of fitness". APNs must hold a current RN license in Tennessee or a compact state if home state is a compact state. APNs who prescribe must have protocols that are jointly developed by the APN and the supervising physician. Medical Board rules that govern the supervising physician of the APN prescriber are jointly adopted by the BOME and BON. Physicians who supervise APN prescriber practices are not required to be on site, but must personally review and sign 20% of the charts within 30 days. CRNAs and 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.

Reimbursement

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

Prescriptive Authority

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

Texas

http://www.tbon.state.tx.us

http://www.cnaptexas.org

http://www.texasnp.org

✪ 2007 Legislative Activity

In the 2007 Texas Legislative Session, no bills passed that expanded or restricted the authority of APNs. However, APNs actively protected their interests. The pay category for NPs employed by the state was increased by two grades. Eight bills were enacted that referred to "RNs," "providers," "practitioners" or "APNs" that would have referred to "physicians" if APNs had not been strongly represented at the Texas Capitol. An attempt to limit the ability of APNs to independently perform sports physical exams for student athletes was also defeated. The BON's Sunset Bill passed, reauthorizing the agency until 2017, and changing the name of the Board of Nurse Examiners to the Texas Nursing Board. The APRN Compact was also enacted. The retail clinics supported HB 1096 that would have reduced the amount of physician supervision required in alternate practice sites. The bill was opposed by medical organizations and did not pass the House.

Legal Authority

The BON is authorized by the NPA to regulate APNs. Although RNs may practice based on a multi-state licensure privilege, APNs must apply for authorization to practice as an NP, CNM, CRNA, or CNS. The APN's SOP is based on advanced practice education, experience, and the accepted SOP of the particular specialty. Unless NPs receive a waiver, the BON will only recognize NPs educated in nine specialties for entry into practice: 1) adult acute care; 2) pediatric acute care; 3) adult; 4) family; 5) geriatric; 6) neonatal; 7) pediatric; 8) psychiatric-mental health; and 9) women's health. The APN acts independently and/or in collaboration with the

healthcare team. The authority to make a medical diagnosis and write Rx must be delegated by a MD or DO using written general delegation protocols or collaborative agreement. The rules refer to protocols as written authorization to provide medical aspects of care. Protocols should allow the APN to exercise professional judgment and are not required to outline specific steps the APN must take. Hospitals may extend privileges to APNs but are not required to do so. Hospitals electing to extend clinical privileges to APNs must use a standard application form, and afford due process rights in granting, modifying, or revoking those privileges.

Reimbursement

All APN categories are eligible for direct Medicaid reimbursement at 92% of physician payment rates. Under certain circumstances, physicians in the Texas Medicaid Program may bill for an APN'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. APNs are listed in the Texas Insurance Code as practitioners that must be reimbursed by indemnity health insurance plans. All HMOs and PPOs in Texas must list an APN on provider panels if the APN's collaborating physician is on the panel and the physician requests that the APN also be listed.

Prescriptive Authority

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

Utah

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

✪ 2007 Legislative Activity

NPA was amended to include CRNAs subsumed in the licensure category of APRNs; however, CRNA scope of practice remained unchanged and authorizes a CRNA to select, order, and administer medications. The term "without prescriptive practice" means a CRNA may not write a prescription for a patient to be filled at a pharmacy. The CRNA may write medication orders within a facility including pre- and post-op.

NPA was amended through H.B. 299, stating that a person who is convicted of, pleads guilty to, or has a plea in abeyance for a violent felony is barred from nurse licensure in Utah. Those guilty of nonviolent felonies may not apply for licensure until 5 years prior discharge of sentence.

Nurse Midwife Practice Act was amended, changing the requirements for licensure. As of January 1, 2010, a graduate degree in nurse midwifery is required to be licensed as a CNM in Utah.

Legal Authority

The Utah BON in collaboration with the Division of Occupational and Professional Licensing (DOPL) grants authority to practice via licensure with an "APRN" or "APRN-CRNA without prescriptive practice" license and regulates the practice of APRNs and CRNAs. Licensed APRN categories include NPs, CNSs, psychiatric/mental health nurses And CRNAs. CNMs are regulated by a separate practice act and CNM board. APRNs practice independently except for the act of prescribing controlled substances Schedules II-III, where a consultation and referral plan is required. The APRN SOP is defined by set standards from national professional specialty organizations, APRNs are not statutorily prohibited from admitting patients and holding hospital privileges; however, this is decided upon by the individual institution. All APRNs must be 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. CNMs, APRNs, and CRNAs, are reimbursed by most insurance companies. Board-certified PNPs and FNPs are reimbursed by Medicaid at 100% of the physician rate. CNMs are reimbursed at 65% by Medicare, whereas other APRNs receive reimbursement at 80% of the physician rate.

Prescriptive Authority

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

Vermont

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

Legal Authority

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

Reimbursement

BC/BS reimburses psychiatric NPs using a provider number. All NPs receive Medicaid reimbursement at 100% of physician payment. The state Medicaid program provides enhanced reimbursement to physicians who care for patients covered by both Medicare and Medicaid. The medical case management fee rules do not include NPs as eligible PCPs. Although legislation

requiring or prohibiting third-party reimbursement does not exist, insurance companies may reimburse NPs depending on policies.

Prescriptive Authority

APRNs have full prescriptive authority, including Schedule II-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

http://www.dhp.state.va.us
http://www.vcnp.net/

2007 Legislative & Regulatory Activity

HB 2416 was introduced in the 2007 legislative session and sought to add NPs to the Virginia statute which provides immunity to physicians who fail to review or act on test results they receive, but neither requested or authorized. House Bill 2416, failed to report in the Civil Courts of Justice subcommittee.

Legal Authority

The Virginia BON and BOM have joint statutory authority to regulate licensed nurse practitioners (LNPs). LNPs are defined as NPs, CNMs, and CRNAs. CNSs are registered solely with the BON. The presidents of the BON and BOM each appoint three board members to the Committee of the Joint Boards of Nursing and Medicine to administer LNP regulations. LNPs must be nationally certified to apply for state authorization. LNPs licensed in a category other than CNMs must practice under the medical direction and supervision of a physician. CNMs practice in collaboration and consultation with a licensed physician except for prescriptive authority, which still carries a statutory requirement for supervision. NP practice is based on education and a written protocol. An NP may practice within the parameters of a written protocol with a supervising physician, as defined in regulation. 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 is required to enter into practice in Virginia. In 2004, legislative changes were made to Virginia Code that now include NPs whenever any law or regulation requires a signature, certification, stamp, verification, affidavit, or endorsement by a physician. Among other things, NPs are also authorized to certify medical necessity of durable medical equipment that is to be reimbursed by Medicaid.

Reimbursement

Effective August 1, 2007, the Virginia Department of Medicaid Assistance Services is now enrolling and reimbursing as separate Medicaid providers, the following specialties of NPs at 100% of the physician rate: Pediatric, Adult, Family, Pediatric, Women's Health, Geriatric, Acute Care, Neonatal, and CNMs. Psychiatric NPs will be paid the same rate for psychiatric diagnosis, evaluation and psychotherapy services as a psychiatric clinical nurse specialist, which is 67% of the rate currently paid to Medicaid enrolled psychiatrists. For other procedures, such as physical examinations, 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 does have an "any willing provider" law, but it applies only to mandated providers and, among APNs, only psychiatric CNSs 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-V controlled substances as defined in the LNP's Practice Agreement. A Practice Agreement, developed between the NP and the supervising physician and submitted to the Joint Boards of Nursing and Medicine, lists the drug categories the NP will prescribe. NPs may only prescribe legend drugs if "such prescription is authorized by the written agreement between the NP and physician." The prescription must include the NP's name and prescriptive authority number, and the patient must be informed in writing of the name and address of the supervising physician. Supervision means the physician documents being readily available for medical consultation by the LNP or the patient, with the physician maintaining ultimate responsibility for the agreed-upon course of treatment and medications prescribed. Physicians who enter into a Practice Agreement cannot supervise and direct, at any one time, more than four NPs with prescriptive authority. Physicians who supervise NPs must make periodic site visits, regularly practice in any location where the NP exercises prescriptive authority, and conduct monthly, random review of patient charts on which the NP has entered a prescription for an approved drug or device. The joint regulations of the BON and BOM include requirements for continued NP competency including eight hours of continuing education 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

http://www.doh.wa.gov/nursing/

2007 Legislative Activity

HB 1666 was signed into law in May 2007, permanently authorizing ARNPs to continue to sign Labor and Industry (L and I) accident report forms and certify time loss for injured workers. A bill passed in 2004 first authorized ARNPs to perform these functions without a physician signature, but was scheduled to sunset on June 30, 2007.

Legal Authority

The Nursing Care Quality Assurance Commission grants APNs authority to practice and regulates their practice. APNs are designated as ARNPs. This includes NPs, CNMs, CRNAs, and CNSs in psychiatric/mental health nursing. 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 physician payment. Washington insurance code bans discrimination against RNs, podiatrists, chiropractors, and certain mental health professionals. Rules governing payment to, and inclusion of, nurses prohibit artificial reductions in the level of an indemnification benefit based on a patient's choice of nursing services rather than those of other health providers. A difference in payment between a physician and a nurse who provide the same services must result from the "disparity of fees actually charged by medical doctors and RNs rather than from an arbitrary formula based on assumptions concerning the relative worth of physician-provided services versus nurse-provided services." The law pertains to private insurers and healthcare service contractors. The Women's Health Care Law allows women to directly access a women's healthcare practitioner of their choice, without referral from another provider. The law applies to all insurance carriers regulated by the insurance commissioner and includes ARNP specialists in women's health and midwifery.

Prescriptive Authority

All ARNPs who qualify to receive prescriptive authority have independent authority to prescribe legend and Schedule II-V controlled sub-

stances. The dispensing of Schedules II-IV controlled substances is limited to a maximum 72-hour supply of the prescribed drug. Independent prescriptive authority entails an initial 30 hours of pharmacotherapeutic education within the area of practice obtained within the 2-year period immediately prior to application. For new graduates, if a pharmacokinetic principles course occurred in a graduate program and the program of study occurred within the last 2 years, that qualifies for licensure. 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. Prescriptions are labeled with the ARNP's name.

West Virginia

http://www.wvrnboard.com

Legal Authority

The West Virginia BON grants authority to practice and regulates the practice of ANP. R&R define advanced practice for RNs. ANP includes NPs, CNSs, CNMs, and CRNAs. ANP SOP includes the ability to assess, conceptualize, diagnose, analyze, plan, implement, and evaluate complex problems related to health. The ANP SOP does not require collaboration with a physician unless the ANP is prescribing. The CNM is required to practice in a collaborative relationship with a physician. CRNAs administer anesthesia in the presence and under the supervision of a physician or DDS. Hospital credentialing for ANPs is dependent upon individual hospital policy. All ANPs must have a master's degree in nursing and hold national board certification to enter into practice.

Reimbursement

Family and pediatric NPs receive Medicaid reimbursement at 100% of the physician rate. State law requires insurance companies to reimburse nurses for nursing services, if such services are commonly reimbursed for other providers; however, 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 Health Care Bill provided for direct access, at least annually, to a woman's healthcare provider for a well-woman examination; providers include ANPs (CNMs, FNPs, WHNPs, Adult NPs, GNPs, or PNPs).

Prescriptive Authority

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

Wisconsin

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

Legal Authority

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

Reimbursement

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

Prescriptive Authority

RNs may prescribe legend drugs and controlled substances as a delegated medical act under the NPA. APRNs may receive "Advanced Practice Nurse Prescriber" (APNP) certification from the BON for independent prescriptive authority. Eligible APRNs must be certified by a board-approved APRN national certifying body, have completed 45 contact hours in clinical pharmacology/therapeutics within the 3 years preceding application, pass an APNP jurisprudence examination, and hold a master's degree in nursing or a related health field. DEA numbers are issued to APNPs. The APNP may prescribe Schedules II-V controlled substances and must comply with restrictions regarding prescribing amphetamines and anabolic steroids. Schedule II substances may only be prescribed as an adjunct to opioid analgesic compounds for the treatment of cancer-related pain, narcolepsy, hyperkinesis, drug-induced brain dysfunction, epilepsy, and depression refractory to other modalities, according to the BON. Drug samples may be dispensed if the APRN is certified to prescribe; prepackaged doses may be dispensed independently if the nearest pharmacy is more than 30 miles away.

Wyoming

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

Legal Authority

The Wyoming BON grants APRNs authority to practice and regulates their practice. APRNs are defined as NPs, CNMs, CRNAs, and CNSs. APRNs are not required to have a collaboratory 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. APRNs are statutorily defined as "PCPs" and are legally authorized to admit patients to a hospital and hold hospital privileges. A master's degree in nursing and national board certification is 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.

Prescriptive Authority

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