

AN **NP** EXCLUSIVE



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31st Annual APRN Legislative Update

Improving state practice authority and access to care

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Abstract: *The Annual Legislative Update describes recent legislative and regulatory changes to practice, reimbursement, and prescriptive authority that have the most impact on NPs and other advanced practice registered nurses across the country.*

Keywords: advanced practice registered nurse, legislative update, practice authority, prescriptive authority regulation, statutes, updates

Legislative and regulatory advancements continue with over 20 states reporting passage of legislation and adoption of regulation impacting access to and delivery of healthcare across the United States. A major theme in the 2019 legislative and regulatory sessions is the continued focus on controlled substances (CSs) prescribing for all authorized health-care providers reported in this article under prescriptive authority.

New this year, **Kentucky** has passed legislation requiring passage of a jurisprudence exam administered via the state's Board of Nursing (BON) as a condition for advanced practice registered nurse (APRN) licensure. It is likely that state BONs will monitor this requirement in consideration of future adoption. Although all but four states require passage of a national board certification exam to enter practice at the time of this publication, national board certification exams do not address individual state regulatory requirements for practice and prescriptive authority.

National certification is also required for participation in Medicare and Medicaid regardless of state regulation. Below is a summary of the major legislative and regulatory improvements pertaining to practice authority and prescriptive authority enacted or adopted in 2018. The 2018 update has also included pertinent statutes and regulations enacted or adopted in 2017 where relevant and not previously reported.

The 2019 edition of the Annual Legislative Update highlights the state of **Virginia** for its advancement toward full-practice authority. Virginia marks the 13th state to enact practice authority following a transition to practice period in collaboration with a physician and/or another APRN. On April 4, 2018, Chapter 776 of the Code of Virginia was enacted, authorizing NPs who have completed the equivalent of at least 5 years of full time as a licensed NP in a patient-care team with a physician to practice in the NP role and population foci for which he or she is certified and licensed without a written or electronic practice agreement. The NP must consult and collaborate with other healthcare providers based on clinical condition and establish a plan of referral of complex medical cases and emergencies to a physician or other appropriate provider.

An attestation signed by the patient-care team physician citing completion of the required practice time in the appropriate population is submitted to both the Board of Medicine (BOM) and BON. When verified, the Boards issue a new license authorizing the NP to practice without a practice agreement. Joint BOM and BON regulatory authority of APRNs is maintained.

■ Practice authority

States reporting legislative and regulatory accomplishments in their area of practice authority reported advancements in global and partial signature authority; adoption of APRN consensus model recommendations on APRN role recognition, scope of practice

(SOP), and educational program requirements; ordering home health services; and advances in protocols, collaborative practice agreements, and SOPs.

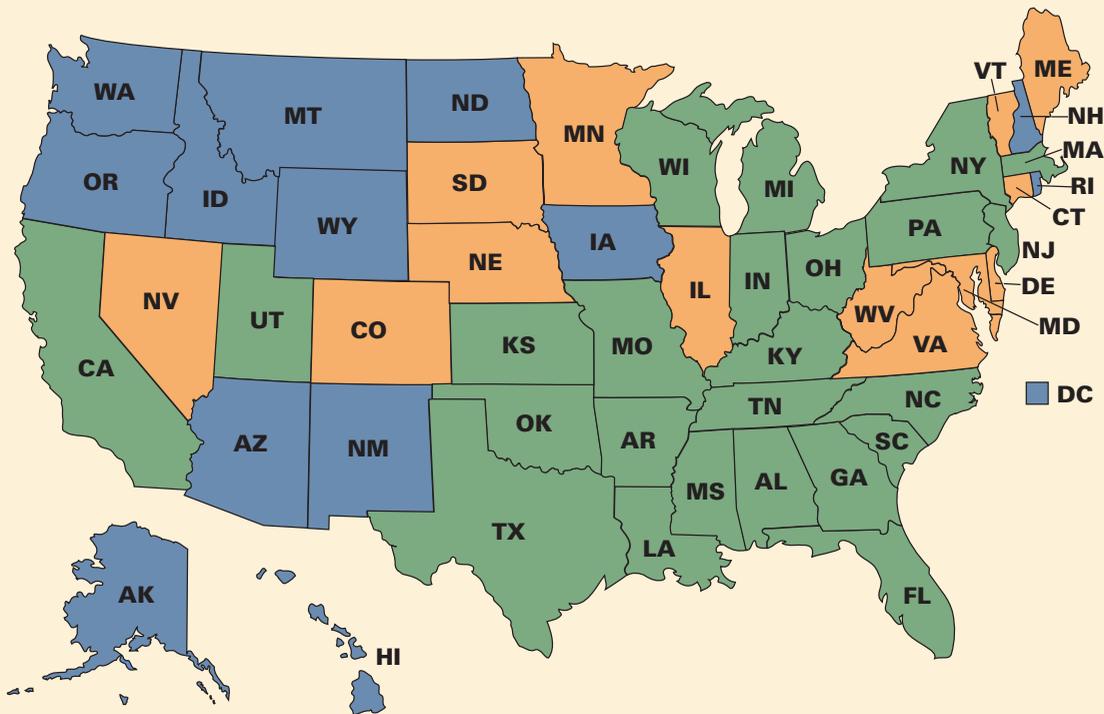
Signature Authority. Six states enacted legislation and/or regulatory amendments affecting partial and global signature recognition and authority, allowing designated APRNs to sign and/or certify certain documents related to healthcare within their defined SOP, including giving authority to designated APRNs to execute nonhospital orders not to resuscitate and orders for life-sustaining treatment.

Authority to certify disability for patients to receive disabled parking tags or placards was achieved in **Alabama** (Act No 2018-474; effective March 28, 2018), and **North Carolina** (Session Law 2017-111; effective July 12, 2017). This provision was extended to both certified nurse practitioners (CNPs) and certified nurse midwives (CNMs) in the respective states. **Alabama's** new law also includes numerous provisions for CNM/CNP authorization including but not limited to performance of physical exams for various forms and organizations including governmental and educational institutions, authorization to order durable medical equipment within all health plans, home health recertification orders, death certificates, residential or inpatient dwellings within the Department of Mental Health, and ambulance transport.

CNPs are now authorized to sign and execute Provider Order of Scope of Treatment forms in **Indiana** (Public Law 67; effective March 13, 2018) and **Michigan** (Public Act 154 of 2017), which includes a medical order specifying whether cardiopulmonary resuscitation should be performed and a medical order concerning the level of medical intervention that should be provided to the qualified person. Similarly, **New York** now authorizes CNPs to execute nonhospital orders not to resuscitate and Medical Orders for Life Sustaining Treatment (MOLST) (Public Law Chapter 430 of 2017; effective May 28, 2018). Finally, **Texas** (SB 919 85(R); effective June 1, 2017) now authorizes APRNs and physician assistants (PAs) to sign medical certifications on death certificates for their hospice and palliative care patients.

Consensus Model adoption. The National Council of State Boards of Nursing now shows 100% implementation of the APRN Consensus Model recommendations in 18 states. These states have adopted all national regulatory standards for APRN licensure, accreditation of APRN educational programs, national

Summary of practice authority for NPs



Full Practice

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

Full Practice with Transition or Reduced Practice with Transition

■ NPs are regulated by a BON or a combination of BON and BOM oversight exists, have full autonomous practice and prescriptive authority but require a post-licensure/certification period of supervision, collaboration, or mentorship: CO*, CT, DE*, IL*, MD*, ME*, MN*, NE, NV*, SD*, VA*, VT, WV^*

Reduced or Restricted Practice

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

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

CO: 1,000-hour post-licensure practice period
 CT: 3-year and a minimum of 2,000-hour post-licensure practice period
 DE: 2-year and a minimum of 4,000-fulltime-hour post-licensure period
 IL: 4,000-hour post-licensure practice period and 250 hours of CE/training units
 MD: 18-month post-licensure practice period
 ME: 24-month post-licensure practice period
 MN: 2,080-hour post-licensure practice period
 NE: 2,000-hour post-licensure practice period
 NV: 2-year or 2,000-hour post-licensure practice period

NY: 3,600-hour post-licensure practice period and attestation of physician collaboration required
 SD: 1,040-hour post-licensure practice period
 VA: 5-year full-time post-licensure practice period
 VT: 2-year and 2,400-hour post-licensure practice period
 WV: 3-year post-licensure practice period; *Excludes Schedules I, II controlled substances, antineoplastics, radiopharmaceuticals, and general anesthetics
 * State may not require post-licensure/certification period of supervision, collaboration, or mentorship when an experienced NP endorsing into the state has met the regulatory requirement through experience in another state

board certification in respective APRN roles, and educational program requirements.¹ This year, two states reported legislative advancement to full adoption in the areas of APRN title, licensure, and recognition, as well as accreditation of educational programs.

The national standard for licensing title is “Advanced Practice Registered Nurse.” **Florida** (Chapter No. 2018-106; effective October 1, 2018) has enacted a new law replacing “Advanced Registered Nurse Practitioner (ARNP)” with APRN and provides for APRN

licensure by the BON. APRNs now include the CNP, CNM, certified registered nurse anesthetist (CRNA), and clinical nurse specialist (CNS) roles. CNSs are newly designated as APRNs with this new law. Additionally, **Indiana** has enacted legislation replacing “advanced practice nurse” with “advanced practice registered nurse” throughout the Indiana Code (Senate Enrolled Act 410; effective July 1, 2018). This new statute requires current national APRN certification or certification equivalence (to be defined in BON regulation) for renewal of prescriptive authority.

APRN licensure candidates in **Kentucky** (Public Acts, Chapter 183; signed April 26, 2018) are now required to pass a jurisprudence exam as a condition of licensure. BON regulations have not been adopted at the time of this publication, and therefore, implementation has not begun. Additionally, Kentucky has amended KRS 314.042(a) pertaining to APRN educational programs, requiring preparation in one of the four recognized APRN roles from an accredited program. This amendment updates the current program requirement to be consistent with national standard.

Ordering home health services. Building on the 2018 survey question regarding state statutory authority to order home health services, survey respondents provided additional information for 2019. If the home health agency is Medicare- and/or Medicaid-certified, 42 Code of Federal Regulation 484.18(c) requires a physician signature to order home health services in all states except for Washington State’s Medicaid program, although rules are in progress to change this. However, some states authorize home health agencies to accept orders from APRNs when patients are private-paying or non-Medicare/non-Medicaid recipients under state law.

This year, seven additional state’s survey respondents confirmed state statutory authorization to order home health. Three states confirmed state law does not prohibit ordering of home health services, and four

additional states have confirmed there is no state statutory authority for NPs to order home health services (see *State response: Home health services authority**).

Advances in protocol/collaborative agreement requirements and SOP. Both **Florida** (Chapter No. 2017-134; effective June 23, 2017) and **Vermont** (Public Act 144; effective May 21, 2018) reported passage of legislation eliminating submission of protocols/practice guidelines to their respective BONs. These documents, however, are still required to be maintained on site in these states. **Illinois** has reported the implementation of Public Act 100-1096 (effective January 1, 2018), amending the Nurse Practice Act (NPA), effectively grandfathering APRNs who have existing collaborative agreements with a podiatric physician to continue in or develop new collaborative agreements with a podiatric physician when the initial collaborative agreement terminates. Only CRNAs may enter into an initial collaborative agreement with a podiatric physician after January 1, 2018.

The **Louisiana** State BON has adopted rule changes to Title 46, Professional and Occupational Standards, Part XLVII, Sections 4505 and 4513, authorizing the APRN’s board-approved collaborating physician to delegate responsibility for consultation and collaboration to an alternate collaborating physician at designated practice sites when defined within the organizational policy. According to the BON, this regulatory update will allow for a streamlined approval process and improve the meaningfulness of the collaborating agreement.

In **Missouri**, improvements in supervision ratios related to collaborative practice agreements with APRNs were signed into law effective August 28, 2018. Act CCS HCS SB 951 now authorizes physicians to enter into a collaborative practice agreement or a supervising agreement with six APRNs, assistant physicians (licensed medical school graduates who have not started residency training; practice restricted to primary care in healthcare shortage areas), licensed physician assistants (PAs), or any combination thereof with exceptions for hospital employees, public health employees, or CRNAs.

Previous law limited the ratio to 1:3. In addition to legislative improvements for APRNs, the **Missouri** BON adopted an emergency rule change to 20 CSR 2200-4.200 on April 26, 2018, increasing the distance between providers with collaborative practice agreements to 75 miles.

State response: Home health services authority*

Authorization: AK, DE, CA, FL, MN, MO, PA, OR, SD, WA, WY
 Authorization not specifically prohibited: AZ, CO, NH
 No Authorization: AL, IA, KS, ME, NC, OK, RI, SD, VA, WV

*States were queried for state statutory or regulatory authorization to order home health services. *The Nurse Practitioner* is aware of federal CMS regulations; if the home health agency is Medicare- and/or Medicaid-certified, 42 Code of Federal Regulation 484.18 (c) requires a physician signature to order home health services.

Total number of active licensed/certified APRNs reported by BONs and/or state nursing associations in 2018

State	Total APRNs	NPs	CNSs	CNMs	CRNAs
Alabama	6,494	4,602	78	16	1,798
Alaska	1,376	1,106	15	62	193
Arizona	8,291	7,827	183	281	900
Arkansas	4,005	3,009	164	33	799
California	32,226	25,046	3,426	1,301	2,453
Colorado	7,123	5,543	597	458	935
Connecticut £	5,018	*	*	!	*
Delaware	1,859	1,253	203	46	357
District of Columbia	1,662	1,375	44	96	147
Florida	22,595	*	144!	*	*
Georgia	12,514	9,684	383	533	1,914
Hawaii £	1,511	*	*	*	*
Idaho	2,065	1,443	44	69	509
Illinois	13,459	10,081	965	470	1,943
Indiana ∞	3,989	*	*	*	!
Iowa	4,609	3,771	75	142	621
Kansas	5,362	3,747	522	85	1,008
Kentucky	8,256	6,524	171	130	1,431
Louisiana	5,808	4,175	132	41	1,460
Maine	2,424	1,799	77	95	453
Maryland	5,935	4,782	115	256	782
Massachusetts	12,112	9,601	67 CNS, 663 PCNS	504	1,277
Michigan ∞	8,916	5,985	!	348	2,583
Minnesota	8,475	5,607	492	2036	340
Mississippi £	3,744	*	!	*	*
Missouri	10,712	8,314	348	141	1,909
Montana	1,528	1,240	41	66	181
Nebraska	2,284	1,622	86	46	530
Nevada £	1,657	*	*	*	*
New Hampshire ∞	1,974	1,546	@	105	313
New Jersey	9,017	*	*	! (BOME)	*
New Mexico	2,586	2,022	123	212!	441
New York	25,940~	25,795	150	!	!
North Carolina	12,006	8,009	243	355	3,399
North Dakota	1,411	953	48	17	393
Ohio (same as last year)	16,760	11,622	1,558	397	3,183
Oklahoma	4,034	2,952	283	70	729
Oregon	4,897	4,048	202	#352	647
Pennsylvania	12,935~	12,704	231	!	!
Rhode Island	1,424	1,050	143	75!	231
South Carolina ∞	3,275	1,797	43	105	1,352
South Dakota	1,619	1,030	66	33	490
Tennessee	14,252	11,271	139	219	2,623
Texas	25,218	18,851	1,322	480	4,565
Utah	2,443	*	*	170	315
Vermont ∞	812	630	39@	74	69
Virginia	10,606	*	419††	*	*
Washington	8,208	6,588	89	482	1,049
West Virginia	3,213	2,305	29	67	812
Wisconsin ∞	3,875+	+	+	+	+
Wyoming	724	552	11	24	137

* Combined with total number of APNs/APRNs for that state

†† Recognized as APRNs but counted separately from other APRN roles

~ "APRN" term is not defined in statute or regulation

! Not recognized as an APRN/ARNP/APN by the BON and not included in Total APRNs

@ Psychiatric clinical nurse specialists recognized as APRNs only

Licensed/certified as NPs by the BON

+ Certified as APNPs (Advanced Practice Nurse Prescribers)

∞ No update to APRN license/certification number was provided by BON.

£ Licensee/certification numbers obtained from BON website

■ Prescriptive authority

Controlled Substances and Medication Assistance Programs. To respond to the national opioid epidemic, 11 states enacted statutory or adopted regulatory changes restricting prescribing of certain CSs, requirements to review and monitor the state's prescription drug monitoring program (PDMP) prior to prescribing CSs, and/or authorization for APRNs to prescribe or dispense buprenorphine as part of the Medication Assistance Programs.

These statutory and regulatory changes apply to all APRNs authorized to prescribe CSs, regardless of licensure category. The following summary limits legislative and regulatory changes to APRNs and includes statutory and regulatory changes occurring in 2017 when noted. Additional information may be included in the individual state summary or by reviewing the new statutes or regulations online.

This year, several states have implemented laws or adopted regulations restricting the number of pills prescribed, morphine milligram equivalents (MME), and duration of opioid treatment when a CS is necessary. In a special legislative session, **Arizona** (Chapter 243; effective April 26, 2018) added restrictions to the length and dosage of opioid and benzodiazepine prescriptions with exceptions and added NPs with an advanced pain certification to those providers authorized to serve as a medical director in pain clinics.

The passage of Public Act 221 in **Colorado** (effective May 21, 2018) now restricts the number of opioid pills all healthcare prescribers may provide a patient as well as stipulates requirements for query of the PDMP. Prescriptions must limit supply to 7 days when a patient has not had an opioid prescription in the last 12 months by that APRN (or other authorized healthcare provider). The APRN may use his or her discretion to include a second fill for a 7-day supply only after querying Colorado's PDMP. Exceptions to the new law in summary include provisions for chronic pain, cancer-related pain, postsurgical pain in certain circumstances, and palliative or hospice care, with provisions, see the Public Act for specific requirements.

The **Ohio** BON reported implementation of Rule 4723-9-10 of the Ohio Administrative Code, limiting the prescribing of opioid analgesics by APRNs when prescribed for acute pain. Restrictions include a 7-day supply of opioids for adults without refills and not more than a 5-day supply for minors with parent

or guardian consent. Exceptions to the 7- and 5-day limit are included in regulation. Extended-release and long-acting opioids are restricted for the treatment of acute pain.

Tennessee limits opioid prescriptions to up to a 3-day supply with a total of 180 MME for those 3 days. Exceptions apply for procedures that are more than minimally invasive or when other reasonable and appropriate nonopioid treatments have been attempted and failed with duration of therapy and MME restrictions, respectively (Public Chapter 1039; effective July 1, 2018). Advisement of risks associated with opioid use during pregnancy and availability and effectiveness of birth control options must be provided to women of childbearing age (ages 15- to 44-years-old) when prescribing more than a 3-day supply of an opioid or opioid dosage that exceeds a total of 180 MME (Public Chapter 901; effective July 1, 2018).

In addition to the states referenced above, several states have enacted legislation or adopted regulations requiring prescribers to consult with or query the state's PDMP. Effective July 31, 2017, **Arkansas's** Public Act 820 of 2017 requires all prescribers to check the PDMP each time a prescription is written for a CS Schedule II or III opioid or for the first time a prescription is written for a benzodiazepine. Exceptions include, but are not limited to, administration (before or during surgery) in a healthcare facility or in an emergency. Additional exceptions relate to palliative or hospice care and licensed long-term care residents among others.

Effective October 2, 2018, **California** prescribers must query the Controlled Substance Utilization Review and Evaluation System (CURES) prior to the first time prescribing, ordering, administering, or furnishing a Schedule II, III, or IV CS within the 24-hour period prior to the appointment or previous business day, unless exempted. Additionally, the CURES system must be consulted before subsequently prescribing a CS if previously exempt and at least once every 4 months if the CS remains part of the patient's treatment plan. Exemptions are broad and provided within California's Health and Safety Code Section 11165.4.

In **Illinois**, all prescribers with an IL-CS license are required to enroll in the PDMP and are required to attempt to check the PDMP prior to writing an initial prescription of a Schedule II CS (Public Act 100-0564; effective January 1, 2018). Rolling effective dates for mandatory query of the **Indiana** Scheduled

Prescription Electronic Collection and Tracking (IN-SPECT) program database when distributing or prescribing CSs during the NP's practice in certain circumstances will be required. The enactment of Indiana's Senate Enrolled Act 221 provides for a 4-year stepped approach for query of the database.

The **South Dakota** BON reported adoption of rule changes effective July 30, 2018, requiring NPs and CNMs to register with the state's PDMP and provide regulatory documentation requirements, including instructions of risk, progress of treatment, and consultation with other healthcare providers when prescribing CSs (General Rules Chapter 20:62:03:11).

Washington State's Nursing Care Quality Assurance Commission adopted opioid rules effective November 1, 2018. The rules apply to opioid prescribing for patients who have acute, subacute, and chronic pain not related to cancer, an expansion of the initial 2011 rules, which applied to chronic pain not related to cancer only. Requirements when ARNPs prescribe opioids include, but are not limited to, a query of the prescription monitoring program at proscribed points of care; notification of the patient regarding risks, storage, and disposal; use of nonpharmacologic modalities to treat pain; and requirements for evaluation and treatment of the patient. Rules also include limits for the quantity, which can be prescribed with a 7-day supply during an episode of acute pain and a 14-day supply during the subacute phases.

Authorization to improve access to addiction treatment continues to increase throughout the country, with implementation of the federal CURES Act through adoption of new state regulations. **Colorado** has implemented a new pilot program authorizing NPs to administer medication-assisted treatment, including buprenorphine therapy, upon completion of required federal training. These pilot programs are intended to improve access to addiction treatment following passage of Public Act 226 effective May 22, 2017.

Effective August 28, 2018, APRNs in **Missouri** are authorized to prescribe up to a 30-day supply of buprenorphine for patients receiving medication-assisted treatment for substance use disorders following mandated federal training. This new statute mirrors the Comprehensive Addiction and Recovery Act (CARA) signed into law by President Barack Obama in 2016, recognizing APRNs as providers of care within medication assistance programs. Similarly, **South Carolina**

now authorizes the Department of Health and Environmental Control to issue registration to NPs (as well as CNMs, CNSs, and PAs) for dispensing medication-assisted treatment for the purposes of maintenance assistance or detoxification treatment (Public Act 216; effective May 31, 2018).

Continuing education (CE). Six states have enacted statutory or regulatory changes to CE requirements pertaining to prescriptive authority and specifically to CS prescribing. **California** enacted Chapter 693, effective September 22, 2018, requiring addition of risks of addiction associated with the use of CS to be included in initial and CE pharmacology courses required for prescriptive authority. **Indiana's** NPs registered for CSs authority must complete 2 hours of CE during the previous 2 years addressing the topic of opioid prescribing and opioid abuse (Senate Enrolled Act 225; effective July 1, 2019).

Maryland prescribers authorized to prescribe controlled dangerous substances through state registration must complete 2 hours of CE and make an attestation of completion before initial registration or renewal of CSs registration (Chapter 213; approved April 24, 2018). **New Jersey** BON has implemented regulatory revision pertaining to educational requirements for APRN certification. Applicants must complete 6 contact hours related to controlled dangerous substances, including pharmacologic therapy and addiction prevention and management by an accredited college or university or organization approved by a credentialing agency (New Jersey Administrative Code 13:37-7.2). In **Washington**, a one-time, 4-hour CE course will be required if the ARNP prescribes opioids. 

REFERENCE

1. National Council of State Boards of Nursing. Consensus Model Implementation Status. 2018. www.ncsbn.org/5397.htm.

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Alabama

www.npalliancealabama.org
www.abn.alabama.gov
www.campaignforaction.org/state/alabama

■ Legal authority

APRNs are defined as APNs in Alabama and include CNP (CRNP in statute), CNS, CNM, and CRNA roles. Although the BON has sole authority to establish the qualifications and certification requirements of APNs through R&Rs, the BON and BOME regulate the collaborative practice of physicians with CRNPs and CNMs, requiring them to practice with BON- and BOME-approved collaborative practice agreements. The collaborating physician and CRNP or CNM must sign written protocols. *Collaboration* does not require direct, on-site supervision by the collaborating physician. It does, however, require such professional oversight and direction as may be required by the R&R of the BON and BOME.

The CRNP or CNM and collaborating physician shall be present in any approved practice site for a minimum of 10% of the CRNP/CNM's scheduled hours if the CRNP or CNM has less than 2 years of collaborative practice experience. Remote practice site is defined in rule, and the collaborating physician must visit each remote site at least twice annually. CRNP SOP is defined in statute and regulation; APNs practice in accordance with national standards and functions identified by the appropriate specialty-certifying agency, congruent with Alabama law.

CRNPs are required to hold an MSN degree and national certification upon entry into practice, with a few exceptions, pursuant to Alabama Board of Nursing Administrative Code Chapter 610-X-5.

■ Reimbursement

There are no legislative restrictions for APNs on managed-care panels. The Alabama

Medicaid Program enrolls and reimburses CRNPs independently pursuant to supervision rules; however, a CRNP who is employed and reimbursed by a facility that receives reimbursement from the Alabama Medicaid program for services provided by the CRNP may not enroll. BC/BS will reimburse CRNPs and CNMs in collaboration with a preferred physician provider at 70% of the physician rate.

■ Prescriptive authority

CRNPs and CNMs may prescribe, administer, and provide therapeutic tests and drugs within a BON- and BOME-approved protocol and formulary. CRNPs and CNMs in collaborative practice with a physician may prescribe Schedules III, IV, and V CSs, pursuant to the rules of the Alabama BOME Chapter 540-X-18, and, under limited circumstances, may prescribe Schedule II CSs, pursuant to BOME Administrative Code Chapter 540-X-20. CRNPs and CNMs are required to complete 12 continuing medical education contact hours in advanced pharmacology and prescribing trends and 4 additional contact hours every 2 years for renewal of the Qualified Alabama Controlled Substances Certificate under current regulation for Schedules III–V CS authority.

Alaska

www.commerce.alaska.gov/web/cbpl/professionallicensing/boardofnursing.aspx
<https://anpa.enpnetwork.com>
www.campaignforaction.org/state/alaska

■ Legal authority

APRNs are regulated by the Alaska BON, defined in statute, and include CNP, CNS, CNM, and CRNA roles. APRNs are further defined as RNs who, due to specialized education and experience, are certified to

perform acts of medical diagnosis and prescription as well as dispense medical, therapeutic, or corrective measures under regulations adopted by the BON. Regulations require that an APRN must have a plan for patient consultation and referral, but a physician relationship is not required.

APRN SOP is directly defined under regulation 12 AAC 44.430, currently under revision and expected to change during the winter of 2018. The regulation refers to the national certifying body for definition of SOP in specialty areas. APRNs in Alaska are statutorily recognized as PCPs. Nothing in the law precludes admitting privileges for APRNs. Entry into APRN practice requires a graduate degree in nursing and national board certification. CE requirements for APRNs are to maintain current national certification. All CNPs, CNSs, CNMs, and CRNAs have been incorporated under the same set of regulations.

■ Reimbursement

All healthcare in Alaska is provided on a fee-for-service basis, and managed care does not exist. FNPs, PNPs, PMHNPs, CNMs, and CRNAs are authorized by law to receive Medicaid reimbursement; NPs receive 85% of the physician payment. A nondiscriminatory clause in the insurance law allows for third-party reimbursement to NPs; Alaska legally requires insurance companies to credential, empanel, and/or recognize APRNs. Alaska does not have "any willing provider" language in current law.

■ Prescriptive authority

Authorized APRNs have independent prescriptive authority, including Schedules II–V CSs, and hold DEA registration. APRNs are legally required to review the Prescription Drug Monitoring Program database prior to prescribing CSs. They are legally

Legislative update key

ANP Advanced Nurse Practitioner	CNP Certified Nurse Practitioner	NCSBN National Council of State Boards of Nursing
APN Advanced Practice Nurse	CNS Clinical Nurse Specialist	NM Nurse Midwife
APNP Advanced Practice Nurse Prescriber	CPA Collaborative Practice Agreement	NPA Nurse Practice Act
APRN Advanced Practice Registered Nurse	CPNP Certified Pediatric Nurse Practitioner	NPI National Provider Identifier
ARNP Advanced Registered Nurse Practitioner	CRNA Certified Registered Nurse Anesthetist	PA Physician Assistant
ASTC Ambulatory Surgical Treatment Center	CRNP Certified Registered Nurse Practitioner	PCP Primary Care Provider
BC/BS Blue Cross/Blue Shield	CS Controlled substance	PCNS Psychiatric Clinical Nurse Specialist
BOM Board of Medicine	DEA Drug Enforcement Administration	PDMP Prescription Drug Monitoring Program
BOME Board of Medical Examiners	DO Doctor of Osteopathic Medicine	PMHNP Psychiatric-Mental Health Nurse Practitioner
BON Board of Nursing	FNP Family Nurse Practitioner	PNP Pediatric Nurse Practitioner
BOP Board of Pharmacy	FPA Full Practice Authority	RNP Registered Nurse Practitioner
BRN Board of Registered Nursing	GNP Geriatric Nurse Practitioner	R&R Rules and Regulations
CHAMPUS Civilian Health and Medical Program of the Uniformed Service	HMO Health Maintenance Organization	SOP Scope of Practice
CNM Certified Nurse Midwife	MCO Managed Care Organization	WHNP Women's Health Nurse Practitioner

authorized to request, receive, and dispense pharmaceutical samples in Alaska. Prescriptions are labeled with the APRN's name only. To renew prescriptive authority, APRNs must maintain national certification and complete 2 CE hours in opioid prescribing each 2-year renewal cycle.

Arizona

www.azbn.gov

<http://arizonanp.enpnetwork.com>

www.campaignforaction.org/state/arizona

■ Legal authority

The Arizona State Legislature grants APRNs authority, and the BON alone regulates their practice. APRNs include CNPs (RNs in statute), CNSs, CNMs, and CRNA roles. According to Arizona Revised Statutes Title 32, Chapter 15 32-1601; 20 (vi), the following language was added to both the RNP and the CNM definition:

...recognizing the limits of the nurse's knowledge and experience by consulting with or referring patients to other appropriate healthcare professionals if a situation or condition occurs that is beyond the knowledge and experience of the nurse or if the referral will protect the health and welfare of the patient.

No formal collaboration agreement is required. RNP SOP is defined in the Arizona Administrative Code R4-19-508. In the SOP, RNPs are authorized to admit patients to healthcare facilities, manage the care of admitted patients, and discharge patients. However, Arizona Department of Health regulations require that patients admitted to an acute care facility must have an attending physician. Acute care facilities apply this citation as the basis to deny independent admitting and hospital privileges to RNPs.

RNPs, CNMs, and CNSs must have a graduate degree in nursing and national board certification in their focus area to begin practice. CRNAs must have a graduate degree associated with an accredited CRNA program and hold national certification to begin practice. For CRNA SOP, it was clarified that a physician or surgeon is not liable for any act or omission of a CRNA who orders or administers anesthetics. CRNAs, therefore, are responsible for their own practice.

■ Reimbursement

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

■ Prescriptive authority

RNPs have full prescribing and dispensing authority, including CSs Schedules II–V, on application, and fulfillment of BON-established criteria. RNP prescribing and dispensing authority is linked to the RNP's area of population focus and certification. For example, women's health RNPs are not authorized to prescribe medication to males except in cases of partner therapy for sexually transmitted infections. Prescribing without documenting an assessment is a violation of the NPA.

An RNP with prescribing and dispensing authority who wishes to prescribe a CS must apply to the DEA for a registration number and submit this number to the BON and the BOP. Drugs (other than CSs) may be refilled for up to 1 year. The passage of ARS 36-2606 requires RNPs who intend to hold or already hold a DEA registration number to also hold Controlled Substances Prescription Monitoring Program (CSPMP) registration issued by the BOP.

Effective October 1, 2017, prescribers must obtain a patient utilization report from the CSPMP's central database prior to prescribing an opioid analgesic or benzodiazepine CSs in Schedules II, III, or IV (with certain exceptions). Language has been added to the SOP for CRNAs to clarify that CRNAs may administer anesthetics and issue medication orders for medications, including CSs, to be administered by a licensed, certified, or registered healthcare provider preoperatively, postoperatively, or as part of a procedure. CRNAs are not authorized to prescribe or dispense medications for patients to use outside of the CRNA's practice setting. CNSs do not have prescriptive authority in Arizona.

Arkansas

www.arsbn.org

www.arna.org

www.campaignforaction.org/state/arkansas

■ Legal authority

The BON grants APRNs authority to practice per an additional license separate from RN licensure. APRNs include CNP, CNM, CNS, and CRNA roles, who practice independently with the exception of RNPs (NPs who do not hold national certification). A collaborative practice agreement with a physician and prescribing protocols are required for prescriptive authority (see below). Standards for all APRN nursing practice are defined within Arkansas State Board of Nursing Rules Chapter 4, Section VI, which include APRN SOP. APRNs practice in accordance with the standards established by the national certifying body from which the

APRN holds his or her certification required for licensure.

Hospital privileges for APRNs are determined on a hospital-to-hospital basis according to the credentialing committee of each hospital. Two-thousand hours of active practice as a registered nurse, graduate- or postgraduate-level APRN education, and national board certification are required for initial APRN licensure. Current national certification must be maintained to continue to hold an active APRN license.

■ Reimbursement

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

■ Prescriptive authority

The NPA authorizes the BON to provide a certificate of prescriptive authority to qualified APRNs. CRNAs are not required to have prescriptive authority to provide anesthesia care, including the administration of drugs or medication necessary for such care. Prescriptive authority includes legend drugs, therapeutic devices, and Schedules III–V CSs, and only hydrocodone combination products reclassified to Schedule II as of October 6, 2014.

Prescribing of hydrocodone combination products is limited to 7 days for acute pain. A collaborative practice agreement with a practicing physician who has training in scope, specialty, or expertise to that of the APRN as well as use of prescriptive protocols is required when prescriptive authority is exercised. All prescribers are required to review the PDMP prior to prescribing an opioid from Schedule II or III CSs and benzodiazepines when prescribing to a patient for the first time and every 6 months thereafter. PDMP review exceptions are described under Arkansas State Board of Nursing Rules Chapter 4, Section VIII (K).

Under the Chapter 4 Rules, an initial applicant for prescriptive authority must hold an active APRN license with completion of pharmacology course work of 3 graduate credit hours or 45 contact hours in a competency-tested pharmacology course; have 300 hours of precepted prescribing experience; and include a collaborative practice agreement with a physician.

Endorsement applicants must provide prescribing evidence of at least 500 hours in the last year and have a clear DEA history.

APRNs who have fulfilled requirements for prescriptive authority may receive pharmaceutical samples and therapeutic devices appropriate to their area of practice. APRNs with prescriptive authority have implied authority to give prescriptive drug samples to patients.

California

www.rn.ca.gov

www.canpweb.org

www.campaignforaction.org/state/california

■ Legal authority

The California BRN grants legal authority to practice and regulates/issues separate certification to APRNs. Defined in statute, APRN includes CNP (NP in statute), CNM, CRNA, and CNS roles. NPs function under “standardized procedures” or protocols when performing medical functions, collaboratively developed and approved by the NP, physician, and administration in the organized healthcare facility in which they work.

NP SOP is defined within the standardized procedure commensurate with the NP’s education and training, not in statute or regulation. CNPs and CNMs are statutorily recognized as PCPs in California’s Medi-Cal system (Medicaid). APRNs are not legally authorized to admit patients to the hospital; however, individual hospitals may grant APRNs hospital privileges. CNPs and CNSs must hold a minimum of a master’s degree in nursing or a health-related field to practice; however, California does not require national certification to enter into practice. CRNAs are required to hold national certification to practice in the state of California.

■ Reimbursement

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

■ Prescriptive authority

CNPs and CNMs may “furnish,” or order drugs or devices, including Schedule II–V

CSs, when the drugs or devices are furnished by a CNP or CNM in accordance with a standardized procedure and when separate authorization is granted by the BRN. Legislation passed in 2017 codifies in California law federal authority for NPs to furnish or order buprenorphine when done in compliance with the provisions of the Comprehensive Addiction and Recovery Act (Public Law 114-198).

Effective October 2, 2018, all prescribers are mandated to consult the Controlled Substance Utilization Review and Evaluation System the first time a patient is prescribed, ordered, administered, or furnished a CS (with some exemptions) and at least once every 4 months if the CS remains a part of the patient’s treatment plan (with some exemptions).

The act of *furnishing* is legally the same as prescribing and requires physician supervision of the CNP and CNM; however, the physician’s physical presence is not required. CNPs and CNMs may request, receive, and dispense pharmaceutical samples and may dispense drugs, including CSs. CNSs and CRNAs do not have prescriptive authority in California.

Colorado

www.dora.colorado.gov/professions/nursing

www.nurses-co.org

www.campaignforaction.org/state/colorado

■ Legal authority

The State BON grants advanced practice authority to RNs who meet the criteria set forth in the Colorado NPA and the BON R&Rs for inclusion on the Advanced Practice Registry (APR), regulates the practice of APRNs, and affords title protection. APRNs are defined as APNs in the State of Colorado and include CNP (NP in statute), CNS, CNM, and CRNA roles. APNs are considered independent practitioners. National certification in a role and population focus is required of all APR applicants.

APNs listed on the registry prior to July 1, 2010, may retain their listing on the APR without certification long as the APN does not allow his or her advanced practice authority to lapse or expire. APNs engaged in an independent practice must be covered by professional liability insurance.

The scope of advanced practice nursing is based on the professional nurse’s SOP within the APN role and population focus, which may include, but is not limited to, performing acts of advanced assessment, diagnosing, treating, prescribing, ordering, selecting, administering, and dispensing diagnostic and therapeutic measures.

The NPA and BON rules do not address, and therefore do not prohibit APNs being designated as PCPs or being granted hospital privileges; however, APNs are not currently recognized as PCPs in statutes and regulations under the jurisdiction of state agencies regulating healthcare. CNMs are now a recognized provider type for Colorado’s Medicaid program, which is known as Health First Colorado.

■ Reimbursement

Medicaid reimburses APN services; however, some managed-care Medicaid companies restrict independent APNs from joining networks. Third-party reimbursement is available to APNs, but third-party payers are not mandated to credential, empanel, or reimburse APNs.

■ Prescriptive authority

APNs have full prescriptive authority authorized by the BON within their recognized role and population focus, including Schedules II, III, IV, and V CSs. APNs applying for original prescriptive authority must have 3 years of clinical work experience as an RN to be eligible to apply for provisional prescriptive authority (RXN-P) per CRS 12-38-111.6(4.5)(a)(VII). The RXN-P must complete a 1,000-hour documented prescribing mentorship period with a physician or an APN who has full prescriptive authority and registration with the DEA.

APNs who have active prescriptive authority in another state and greater than 1,000 hours of safe prescribing experience in that state are not required to complete a 1,000-hour documented prescribing mentorship period.

An articulated plan for safe prescribing and one-time attestation signature is required following completion of the mentorship or upon prescribing in Colorado with full prescriptive authority by endorsement, for verification, and the existence of an articulated plan for safe prescribing. The APN is responsible for reviewing his or her articulated plan on an annual basis, and articulated plans may be audited by the BON.

Safe opioid prescribing legislation enacted in 2018 requires APRNs, among other prescribers of opioid medications, to limit supply to 7 days when a patient has not had an opioid prescription in the last 12 months by the same APRN. The APRN may use his or her discretion to include a second fill for a 7-day supply. Exceptions to the new law are described in Colorado Revised Statutes 12-38-111.6 and in summary include provisions for chronic pain, cancer-related

pain, postsurgical pain in certain circumstances, and palliative or hospice care, with provisions (see statute for specific requirements). Prior to prescribing the second fill of any opioid prescription, the APRN must query the PDMP with some exceptions as described in Colorado Revised Statutes 12-42.5-404.

BON rules authorize APNs with prescriptive authority to receive and distribute a therapeutic regimen of prepackaged and labeled drugs, including free samples.

Connecticut

<https://portal.ct.gov/DPH/Public-Health-Hearing-Office/Board-of-Examiners-for-Nursing/Board-of-Examiners-for-Nursing>
www.ctaprn.org

www.campaignforaction.org/state/Connecticut

■ Legal authority

APRNs are defined in the NPA, regulated by the Connecticut State Board of Examiners for Nursing, and include CNP (NP in statute), CNS, and CRNA roles. APRNs are granted FPA following no less than 3 years and not less than 2,000 hours of APRN practice in collaboration with a physician. APRN SOP, independent practice, and collaborative practice are defined in statute by the BON. Additionally, the NPA specifically authorizes RNs to operate under an order issued by an APRN. The passage of Public Act No. 16-39 in 2016 authorizes global signature authority for APRNs in several situations, including certification for medical marijuana use (except for glaucoma), among other provisions.

APRNs are statutorily recognized as PCPs and are authorized to admit patients and hold hospital privileges. A graduate degree in nursing or other related field and national board certification are required to enter into practice. CNM authority is regulated by the Department of Public Health, and SOP is recognized under a separate statute (Chapter 377, Midwifery).

■ Reimbursement

Medicaid regulations govern reimbursement to APRNs under the remaining Medicaid fee-for-service programs. NPs, PCNSs, and CNMs are reimbursed for services under state insurance statutes, which affect only private insurers. Reimbursable services must be within the individual's SOP and must be services that are reimbursed if provided by any other healthcare provider. The law further states that insurers cannot require supervision or signature by any other healthcare provider as a condition of reimbursement.

www.tnpj.com

■ Prescriptive authority

APRNs may independently prescribe, dispense, and administer medications autonomously, including Schedules II, III, IV, and V CSs following no less than 3 years and not less than a 2,000-hour transition to practice period. APRNs and CNMs are legally authorized to request, receive, and dispense pharmaceutical samples.

Delaware

<https://dpr.delaware.gov/boards/nursing>

www.denurses.org

www.campaignforaction.org/state/delaware

■ Legal authority

APRNs are licensed and regulated by the Delaware BON and include CNP, CNS, CNM, and CRNA roles. APRNs enjoy FPA as defined in section 1935 of the Delaware NPA; however, the statute is clear that FPA does not equate to the granting of independent practice. The BON may grant APRNs independent practice following review and recommendation of the APRN Committee. *Independent practice* is defined as practice and prescribing by an APRN who is not subject to a collaborative agreement and works outside the employment of an established healthcare organization, healthcare delivery system, physician, podiatrist, or practice group owned by a physician or podiatrist.

Independent practice may be granted when an APRN has submitted written evidence of practice under a collaborative agreement with a hospital or integrated clinical setting for at least 2 years and a minimum of 4,000 full-time hours when the practice is substantially related to the population and focus area of the APRN.

APRNs have authority to serve as PCPs by an insurer or healthcare services corporation. APRNs must graduate from or complete a graduate-level APRN program accredited by a national accrediting body and current certification by a national certifying body in the appropriate role and population focus area to be licensed in Delaware.

■ Reimbursement

Delaware has statutory provisions requiring health insurers, health service corporations, and HMOs to provide benefits for eligible services when rendered by an APRN acting within his or her SOP. APRNs may be listed on provider panels, and some providers are recognizing APNs on managed-care provider panels. CNMs have legislative authority under the Board of Health for third-party reimbursement. FNPs and PNPs also receive

Medicaid reimbursement at 100% of the physician payment.

■ Prescriptive authority

APRNs licensed by the BON may prescribe, order, procure, administer, store, dispense, and furnish over-the-counter (OTC), legend, and CSs pursuant to applicable state and federal laws and within the APRN's role and population focus. APRNs may receive, sign for, record, and distribute sample medications to patients in accordance with state law and DEA laws, regulations, and guidelines.

District of Columbia

<http://doh.dc.gov/service/board-nursing>

www.npadc.org

www.campaignforaction.org/state/district-of-columbia

■ Legal authority

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

■ Reimbursement

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

■ Prescriptive authority

The D.C. regulations provide for full prescriptive authority, including Schedules II, III, IV, and V CSs. The law and R&R authorize prescribing Schedules II, III, IV, and V CSs and allow dispensing of all medications, including sample medication. APRNs are authorized to request and receive pharmaceutical samples. The D.C. Pharmacy Board issues a CS registration to providers with CS authority; however, APRNs must also hold DEA registration. Prescriptions are labeled with the APRN's name.

Florida

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

■ Legal authority

Effective October 2018, APRNs in Florida are now licensed and defined as APRNs and include CNP, CNS, CNM, and CRNA roles. APRN SOP is defined in statute and includes the performance of medical acts of diagnosis, treatment, and operation pursuant to protocols established between the APRN and an MD, DO, or dentist.

Within the framework of established protocols, APRNs may order diagnostic tests, physical therapy, and occupational therapy. The degree and method of supervision (determined by the APRN and MD, DO, or dentist) are specifically identified in written protocols and shall be appropriate for prudent healthcare providers under similar circumstances. Supervision is defined as the ability to communicate or establish contact by telephone; the supervising practitioner's on-site presence is not required.

APRNs are authorized to admit patients to a hospital and hold hospital privileges; however, this authority is dependent upon privileges granted by the institution and the supervising physician. APRN applicants must have a master's degree to qualify for initial certification and are required to hold national board certification to enter practice. CNSs must hold a master's degree in a clinical nursing specialty and either national certification in a CNS specialty or proof of completed clinical experience in a CNS specialty for which there is no national certification.

■ Reimbursement

APRNs receive Medicaid, Medicare, CHAMPUS, and third-party reimbursement; however, Medicaid reimburses APRNs at 100% of the physician rate only if the on-site physician countersigns the chart within 24 hours. Medicaid reimburses APRNs at 85% 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 APRNs based on licensure. Private insurers must reimburse CNM services if the policy includes pregnancy care.

■ Prescriptive authority

APRNs are authorized by supervisory protocol to prescribe, dispense, administer, or order any drug, including Schedules II, III, IV, and V CSs as authorized in a BON-adopted CSs formulary with certain exceptions. Additionally, psychiatric mental health

board-certified APRNs may prescribe psychotropic CSs.

APRNs prescribe under a protocol, which broadly lists the medical SOP and generic categories from which the APRN can prescribe, and the CSs formulary describes limitations and restrictions based on specialty certification, approved uses of CSs, and other restrictions the committee finds necessary to protect the health, safety, and welfare of the public. APRNs are authorized to request, receive, or dispense pharmaceutical samples.

Georgia

<http://sos.ga.gov/index.php/licensing/plb/45>
<https://uaprn.enpnetwork.com>
www.georgianurses.org
<https://campaignforaction.org/state/georgia>

■ Legal authority

APRNs are defined in statute and include CNP (NP in statute), CNM, CRNA, and CNS roles. A master's degree or higher in nursing (or other related field) and national board certification are required for all APRNs at entry into practice (with the exception of CRNAs educated prior to 1999). APRN practice authority is granted through 1 of 2 statutes: OCGA 43-34-25 and OCGA 43-34-23. APRNs authorized to practice under 43-34-23 are regulated by the BON. An APRN is authorized to perform advanced nursing functions and certain medical acts that include, but are not limited to, ordering drugs, treatments, and diagnostic studies through a nurse protocol.

A *nurse protocol* is defined as a written document signed by the NP and physician in which the physician delegates authority to the nurse to perform certain medical acts and provides for immediate consultation with the delegating physician. The issuance of a written prescription is prohibited. APRNs practicing under OCGA 43-34-25 have prescriptive authority. There is joint regulation by the BON and BOM in that APRNs requesting prescriptive authority are required to submit, under BOM rules, a Nurse Protocol Agreement that must be approved by the BOM.

Practice under 43-34-25 prohibits APRNs from ordering certain radiographic imaging tests, such as MRI and computed tomography scans, unless there are "life-threatening situations." There is a universal requirement for periodic review of a sampling of patient records as well as a requirement for patient evaluation and exam by the delegating physician in certain circumstances. Practice is delegated supervisory in nature. APRNs may hold hospital privileges in certain situations.

■ Reimbursement

There are no statutes mandating the third-party reimbursement for APRNs. FNP, PNP, WHNP, CNM, and CRNAs are eligible for Medicaid reimbursement from the Department of Community Health. Reimbursement rates vary: NPs and CRNAs are reimbursed at 90% of the physician payment, and CNMs are reimbursed at 100% of the physician payment. Some private insurers reimburse APRNs but are not required by law to do so.

■ Prescriptive authority

APRNs practicing under a nurse protocol as defined by OCGA 43-34-23, which describes a process that permits RNs (including APRNs) to administer, order, or dispense drugs under delegated medical authority as either prescribed by a physician or authorized by protocol. APRNs practicing under a Nurse Protocol Agreement defined and approved by the BOM as authorized by OCGA 43-34-25 may issue a written drug order, including Schedules III, IV, and V CSs, and request, receive, sign for, and distribute pharmaceutical samples. BON regulations governing protocols used by RNs require the RN to document preparation and performance specific to each medical act. "Medication orders" may be called into a pharmacy.

Hawaii

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

■ Legal authority

The BON licenses and regulates APRNs in Hawaii consistent with the NCSBN APRN Consensus Model. APRNs include CNP (NP in regulation), CNS, CNM, and CRNA roles and have independent SOP and prescriptive authority. The APRN SOP is defined in statute and regulation and conforms to the NCSBN Model Act. Legislation passed in 2016 authorizes APRNs to certify patients for medical marijuana use.

Hospitals licensed in Hawaii recognize APRNs, allow them to function with full SOP, and authorize APRNs to act as a PCP in their institutions. The minimum requirements to enter practice in Hawaii include completion of an accredited graduate-level education program preparing the nurse for one of the four recognized APRN roles and national certification in the APRN's clinical specialty.

■ Reimbursement

Current law provides direct reimbursement to all APRNs and authorizes all insurers to legally recognize APRNs as PCPs. The reimbursement rate ranges from 85% to

100%. NPs and CNSs are also reimbursed through CHAMPUS. Medicaid expanded the types of APRNs they reimburse to include PCNSs and additional NP specialties. Medicaid reimburses at 75% of the physician payment. Med-QUEST, a Medicaid waiver program, defines PNPs, FNPs, and CNMs as PCPs.

■ Prescriptive authority

The BON regulates APRN prescriptive authority, and APRNs have legal authority to prescribe medications, including Schedules II, III, IV, and V CSs independently pursuant to an exclusionary formulary established by the BON. APRNs with prescriptive authority are legally authorized to request, receive, and dispense manufacturers' prepackaged pharmaceutical samples. APRNs may not request, receive, or sign for CS samples; however, they may prescribe, order, and dispense medical devices and equipment. APRN prescribers' prescriptions are labeled with the APRN's name.

Idaho

<https://ibn.idaho.gov/IBNPortal>

www.npidaho.org

www.campaignforaction.org/state/idaho

■ Legal authority

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

APRNs are not statutorily recognized as PCPs; however, Idaho has an "any willing provider" language in statute. APRNs are legally authorized to admit patients to hospitals and hold hospital privileges in Idaho. Some facilities have granted APRNs privileges. State law requires current RN licensure in Idaho, successful completion of an approved graduate or postgraduate APRN program accredited by a national organization recognized by the Board and current national certification by an organiza-

tion recognized by the Board for the specified role.

■ Reimbursement

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

■ Prescriptive authority

Prescribing and dispensing authority is granted to APRNs who have completed 30 contact hours of pharmacology-specific formal instruction beyond basic RN education or who graduated from an APRN education program after December 31, 2015. Authorized APRNs may prescribe and dispense legend and Schedules II, III, IV, and V CSs appropriate to their defined SOP. Authorized APRNs have their own DEA numbers and prescribe independently. APRNs are legally authorized to request, receive, and dispense pharmaceutical samples, and APRN prescriptions are labeled with the APRN's name only.

Illinois

www.idfpr.com/profs/nursing.asp

www.isapn.org

www.campaignforaction.org/state/illinois

■ Legal authority

The Illinois Department of Financial and Professional Regulation (IDFPR) grants authority and regulates APRN practice. APRNs include CNP, CNS, CNM, and CRNA roles. Legislation passed in 2017 grants APRNs FPA as defined in 225 ILCS 65/65-43, eliminating the requirement for a collaborative agreement following a transition to practice period, with some exceptions for prescribing CSs (discussed below in Prescriptive Authority).

The transition to practice period includes completion of 250 hours of CE or training and at least 4,000 hours of clinical experience in collaboration with a physician following national certification in the APRN role. Once completed, the APRN and physician collaborator must file an attestation of completion with the department. APRN SOP is defined in 225ILCS 65/65-30. All APRNs may practice only in accordance with their national certification.

Prior to meeting FPA requirements, APRNs must have a written collaborative agreement with a physician, podiatrist, or dentist, except for APRNs who provide

services in a hospital, hospital affiliate or ASTC, and have been granted clinical privileges by that facility. If a collaborative agreement with a physician or podiatrist is terminated, the APRN is authorized to continue to practice for up to 90 days after the termination of the agreement, provided the APRN seeks any needed collaboration at a local hospital and refers patients who require services beyond the training and experience of the APRN to a physician or other healthcare provider.

New legislation enacted and effective as of January 1, 2018, prohibits new collaborative arrangements with podiatric physicians, except for CRNAs. APRNs who had an existing collaborative agreement with a podiatric physician prior to the enactment of P.A. 100-513 on January 1, 2018, may continue to practice in that collaborating relationship or enter a new written collaborative relationship with a podiatric physician.

The APRN must hold a graduate degree, current RN licensure, and national certification as a CNP, CNS, CNM, or CRNA from the appropriate national certifying body as determined by rule of IDFPR. There is an exception to the graduate degree requirement for CRNAs who completed their CRNA program prior to January 1, 1999, and have kept their certification current. This exception will expire on June 30, 2023.

■ Reimbursement

The Illinois Department of Healthcare and Family Services (HFS) administers the Illinois Medicaid program. APRNs who enroll as providers in the department's medical programs are reimbursed at 100% of the physician rate. Medicaid recipients are being transitioned to Medicaid MCOs; therefore, in addition to enrolling as HFS providers, APRNs must also enroll as providers for each Medicaid MCO for which any of their patients are members. Statutory prohibition for third-party reimbursement to APRNs does not exist. APRNs receive direct or indirect reimbursement from some third-party payers.

■ Prescriptive authority

APRNs with FPA are authorized to prescribe both legend drugs and Schedules II, III, IV, and V CSs and includes selection of, orders for, administration of, storage of, acceptance of samples of, and dispensing OTC medications, legend drugs, and other preparations, including, but not limited to, botanical and herbal remedies. Application for a Mid-Level Practitioner Illinois Controlled Substances License is required to prescribe CSs, in addition to DEA

registration. All prescribers are required to enroll in the Illinois Prescription Monitoring Program (PMP) and required to check the PMP prior to initial prescription of Schedule II narcotics, such as opioids, and document the attempt in the patient's record.

Prescribing benzodiazepines or Schedule II narcotic drugs is authorized only in a consultation relationship with a physician, which must be recorded using the PMP website by the physician and APRN with FPA, and is not required to be filed with the Department of Financial and Professional Regulation. At least monthly, the APRN and physician must discuss the condition of any patients for whom a benzodiazepine or opioid is prescribed.

Prescriptive authority, including prescribing Schedules II, III, IV, and V CSs, may be authorized by clinical privileges in a hospital, hospital affiliate, or ASTC, or may be delegated to an APRN by a physician or podiatrist as a part of the written collaborative agreement during the transition to practice period. Delegation to prescribe CSs must be noted in the written collaborative agreement.

For APRNs prescribing CSs under a written collaborative agreement, the collaborating physician or podiatric physician must have a valid, current Illinois CS license and federal registration. In the case of prescribing Schedule II CSs, such delegation, whether by written collaborative agreement or by privileging by a hospital, hospital affiliate, or ASTC, must identify the specific Schedule II CSs by either brand name or generic name.

Of the 80 hours of CE required for 2-year APRN licensure renewal, a minimum of 20 hours of pharmacotherapeutics must be completed, including 10 hours of opioid prescribing or substance abuse education.

Indiana

www.in.gov/pla/nursing.htm

www.indiananurses.org

www.campaignforaction.org/state/indiana

■ Legal authority

APRNs are defined as APNs in Indiana and include CNP (NP in regulation), CNM, CNS, and CRNA roles. The Indiana State BON grants the authority to and regulates APNs. The BON does not issue additional, separate licenses or certification to NPs or CNSs; however, CNMs must apply for "limited licensure" to practice. APNs without prescriptive authority may function independently in their advanced practice; however, a written CPA is necessary if the APN seeks prescriptive authority.

APN SOP is defined in regulation. National certification is required to obtain prescriptive authority if the APN holds a baccalaureate degree. APNs with a graduate degree do not need to be nationally certified for prescriptive authority to be granted. CNSs are required to hold a minimum of a master's degree to practice.

In hospitals, APNs are authorized to practice in collaboration with a licensed practitioner as evidenced by a practice agreement; by privileges granted by the governing board of a hospital licensed under IC 16-21 (hospitals) with the advice of the medical staff that sets forth the manner in which the APN and licensed practitioner will cooperate, coordinate, and consult with each other; or by privileges granted by the governing body of a hospital operated under IC 12-24-1 (state hospitals) that set forth the manner in which the APN and licensed practitioner will cooperate, coordinate, and consult with each other.

■ 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 the physician payment. Medicaid for children, however, does not allow for NP reimbursement under current managed-care arrangements. Recent legislation in 2016 directs Medicaid managed care and fee-for-service plans to reimburse NPs and CNSs employed by community mental health centers for services as specified.

■ 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 CSs 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 written CPA.

Written CPAs must be approved by the BON and include the manner in which the APN and licensed physician will cooperate, coordinate, and consult with each other on the provision of healthcare, and the specifics of the licensed physician's reasonable and timely review of the APN's prescribing practices, including the provision for a minimum weekly review of 5% random chart sampling. The BON issues a prescriber authority ID number; the authority limits APN

prescribing to within the APN's and collaborating physician's SOP.

APNs requesting authority to prescribe CSs 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. Recent legislation authorizes NPs to prescribe legend drugs to patients receiving care via telemedicine if they have established a provider-patient relationship, satisfy the standard of care, and document the prescription in the medical record.

APNs with prescriptive authority are authorized to prescribe Schedules III and IV CSs for the purpose of weight reduction or to control obesity (Indiana Code 35-48-3-11) after certain conditions are met, which was prohibited under this code until 2015. Additionally, IC 25-1-9-6.8 requires practitioners to follow the most recent guidelines adopted by the American Academy of Pediatrics or American Academy of Child and Adolescent Psychiatry when prescribing stimulant medications for attention-deficit disorder or attention-deficit hyperactivity disorder. CRNAs are not required to obtain prescriptive authority to administer anesthesia.

Iowa

www.nursing.iowa.gov

www.campaignforaction.org/state/iowa

■ Legal authority

APRNs are defined as ARNPs in the state of Iowa. This includes CNP, CNS, CNM, and CRNA roles. The ARNP is certified by a national professional certification organization in at least one population focus, which includes family/individuals across the lifespan, adult/gerontology, neonatal, pediatrics, women's health/gender, and psychiatric mental health.

ARNPs are authorized to practice independently within their specific role and population focus, and collaborative practice agreements are not required by the BON. SOP is broadly defined. ARNPs are statutorily recognized as PCPs; however, state law does not contain "any willing provider" language. ARNPs may hold hospital clinical privileges. Licensure as an ARNP requires current licensure as an RN and certification by a national professional certification organization. The majority of ARNPs are educated at the master's or doctoral level.

■ Reimbursement

Iowa's Medicaid managed-care and prepaid-service programs reimburse ARNPs. Payment of necessary medical or surgical

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

■ Prescriptive authority

Authorized ARNPs are granted full independent prescriptive authority within their specific role and population focus, including Schedules II, III, IV, and V CS medications. ARNPs may prescribe, deliver, distribute, or dispense noncontrolled and controlled drugs, devices, and medical gases, including pharmaceutical samples. ARNPs must register with the DEA, and prescriptions written by ARNPs must be labeled with their name.

Kansas

www.ksbn.org
www.kaanpks.com/
www.campaignforaction.org/state/kansas

■ Legal authority

The Kansas BON grants authority to APRNs and regulates the practice, issuing a separate license. Recognized APRN roles include CNP (NP in regulation), CNS, CNM (NM in regulation), and CRNA (RNA in statute). CNPs, CNSs, and CRNAs function in collaborative relationships with physicians and other healthcare professionals in the delivery of primary healthcare services. The Independent Practice of Midwifery Act in 2016 authorized CNMs to practice without a collaborative agreement when such services were limited to those associated with a normal, uncomplicated pregnancy and delivery.

APRNs make independent decisions about the nursing needs of patients and interdependent decisions with physicians in carrying out health regimens for patients; however, the physical presence of a physician is not required when care is given by the APRN.

Any CNP, CNS, or CRNA who interdependently develops and manages the medical plan of care for patients or clients is required to have a signed authorization for collaborative practice with a physician who is licensed in Kansas (60-11-010 [b]). Each authorization for collaborative practice shall be maintained in either hard copy or electronic format at the APRN's principal place of practice.

SOP is defined in statute and regulation; however, APRNs are not recognized as PCPs.

No specific language in statute authorizes or prohibits hospital privileges; admitting and hospital privileges are determined by individual institution policy and procedure. APRN applicants in all categories require a master's degree or higher in nursing, and national board certification is not required to enter practice in Kansas (except for registered nurse anesthetists).

■ Reimbursement

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

■ Prescriptive authority

APRNs, with the exception of CRNAs, are legally authorized to prescribe medications, including Schedules II, III, IV, and V CSs, pursuant to a collaborative practice agreement and written protocol. The protocol must contain a precise and detailed medical plan of care for each classification of disease or injury for which the APRN is authorized to prescribe and shall specify all drugs, which may be prescribed by the APRN. These can be published protocols or practice guidelines that have been agreed upon by both the APRN and physician.

CNMs may prescribe drugs and devices without a collaborative practice agreement when the service is associated with family planning services, including treatment or referral of a male partner for sexually transmitted infections, initial care of the newborn, and a normal, uncomplicated pregnancy and delivery. The prescription order must be signed by the APRN and include the name of the physician and APRN.

APRNs must register with the DEA and the BON if they prescribe CSs. Prescription labels include both the APRN's and physician's name. APRNs are authorized to request, receive, and distribute pharmaceutical samples, with the exception of CSs, if the drug is within their protocol.

Kentucky

www.kbn.ky.gov
www.kcnpnm.org
www.campaignforaction.org/state/kentucky

■ Legal authority

The Kentucky BON grants APRNs authority to practice and regulates their practice. APRNs are statutorily defined as CNPs,

CNSs, CNMs, and CRNAs. APRNs practice autonomously within their relative SOPs; however, they must practice in accordance with the SOP of the national certifying organization as adopted by the BON in regulation (collaborative agreement is required for certain prescriptive authority; see detail below).

CNP SOP is defined in Kentucky statute KRS 314.011. "APRNs shall seek consultation or referral in situations outside their SOP (201 KAR 20:057, Section 3)." APRNs are recognized as practitioners in statute (KRS 314.195), included in the definition of "practitioner" for prescribing (KRS 217.015 [35], KRS 218A.010 [33]), and are legally authorized to admit patients to a hospital and hold hospital privileges; however, hospital regulations permit medical staff to set conditions (902 KAR 20:016 Section 3 [8][b][2] [b]). A master's degree, doctorate, or postmaster's certificate as an APRN and national board certification are required to enter practice in Kentucky.

■ Reimbursement

The state medical assistance program reimburses APRNs for services at 75% of the physician rate in all state regions. Kentucky is an "any willing provider" state. In April 2003, the US Supreme Court upheld the Kentucky law providing that a health insurer may not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer.

■ Prescriptive authority

Legislation passed in 2018 requires APRNs to pass a jurisprudence exam for prescriptive authority in Kentucky, ensuring APRNs are familiar with the requirements of obtaining and maintaining prescriptive authority for nonscheduled legend drugs and CSs. APRNs have autonomous prescriptive authority for nonscheduled legend drugs following 4 years of prescribing experience under a Collaborative Agreement for Prescriptive Authority for Nonscheduled Drugs (CAPA-NS) with a physician licensed in Kentucky.

Prescribing of Schedules II–V CSs is authorized pursuant to a permanent Collaborative Agreement for Prescriptive Authority for Controlled Substances (CAPA-CS). The CAPA-CS and CAPA-NS define an APRN's scope of prescriptive authority and are signed by the APRN and the physician.

APRNs may prescribe scheduled medications with the following limitations: Schedule II CSs for a 72-hour supply; there

are two exceptions: certified psychiatric/mental health APRNs may prescribe a 30-day supply of psychostimulants, and all APRNs may prescribe a 30-day supply of Schedule II controlled hydrocodone-combination products without refill.

Statute limits all prescribers to a 72-hour supply of Schedule II CSs (including hydrocodone-combination products) when prescribing the Schedule II CS for acute pain, with exceptions including documentation for more than a 72-hour supply for acute pain justifying deviation from the 3-day supply; chronic pain; pain associated with a valid cancer diagnosis; pain associated with end-of-life treatment; part of a narcotic treatment program; pain following a major surgery or treatment of significant trauma; or dispensed or administered directed to an ultimate user in an inpatient setting.

Schedule III CSs may be prescribed for a 30-day supply without refills; Schedules IV and V CSs may be prescribed with refills not to exceed a 6-month supply with the following limitations: diazepam, clonazepam, lorazepam, alprazolam, and carisoprodol may be prescribed for 30 days without refills. Gabapentin was rescheduled as a Schedule V CS in Kentucky in 2017 and will be recorded and monitored in the Kentucky prescription drug monitoring program. CRNAs do not need CAPAs to deliver anesthesia care.

APRNs must complete 5 pharmacology contact hours annually as part of their CE requirement (all APRNs with a CAPA-CS must include 1.5 of the 5 contact hours related to the use of the prescription monitoring system, pain management, or addiction disorders).

APRNs are legally authorized to request and receive, as well as dispense, nonscheduled legend pharmaceutical samples. APRNs may also dispense nonscheduled legend drugs from local, district, and independent health department settings subject to the direction of the appropriate governing board of the individual health department.

Louisiana

www.lsb.state.la.us

www.lanp.org

www.campaignforaction.org/state/louisiana

■ Legal authority

APRNs are licensed by the BON and include CNP (NP in statute), CNM, CRNA, and CNS roles. APRNs perform certain acts of medical diagnosis in accordance with a CPA, a formal written statement addressing the parameters of the collaborative practice that are mutually agreed upon by the APRN, physician(s), or

dentist(s), including consultation or referral availability, clinical practice guidelines, and patient coverage.

APRNs' SOP is addressed in regulation in that "patient services provided by an APRN must be in accord with the educational preparation of that APRN." The APRN SOP includes the following: certain acts of medical diagnosis or medical prescriptions of a therapeutic or corrective nature; prescribing assessment studies; legend and certain controlled drugs; therapeutic regimens; medical devices and appliances; receiving and distributing a therapeutic regimen of prepackaged drugs prepared and labeled by a pharmacist; and free samples supplied by a drug manufacturer (excluding receipt of samples of CSs).

Louisiana state law includes "any willing provider" language, and APRNs are legally authorized to hold hospital privileges. APRNs must be licensed as an RN, possess a master's degree or higher, and be certified by a national certifying body recognized by the BON, or meet "commensurate requirements" if certification is not available.

■ Reimbursement

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

■ Prescriptive authority

APRNs have prescriptive authority in Louisiana, including Schedules II, III, IV, and V CSs. The BON has sole authority to develop, adapt, and revise R&R governing SOP, including prescriptive authority, the receipt and distribution of sample and prepackaged drugs, and prescribing legend and controlled drugs. An APRN who is granted limited prescriptive authority may request approval to prescribe and distribute CSs as agreed upon by the APRN's collaborating physician, and the patient population is served by the collaborative practice. All medical practitioners are limited to prescribe a 7-day supply of opioid medication when issuing a first-time prescription for outpatient use to an adult with an acute condition. Exceptions to the limitation are provided for in the new law.

Past amendment of regulations (Title 46, Part XL VII, §4513) provide for CRNA prescriptive authority without a CPA when prescribing or writing orders in a hospital or other licensed surgical facility for services related to anesthesia care. Rules continue to require a CPA for prescriptive authority of non-CRNAs. New provisions removed the requirement to submit the CPA to the Board.

Maine

www.state.me.us/boardofnursing

www.mnpa.us

www.campaignforaction.org/state/maine

■ Legal authority

The Maine BON authorizes and regulates APRN practice. APRNs licensed by the BON are defined as CNPs, CNMs, CNSs, and CRNAs. CNSs practice in an independent role; however, a CNP who qualifies as an APRN must practice for at least 24 months under the supervision of a licensed physician, NP, or must be employed by a clinic or hospital that has a medical director who is a licensed physician. The CNP must submit written evidence to the BON upon completion of the required clinical experience. Following this period, the CNP practices independently.

CRNAs are responsible and accountable to a physician or dentist except for services provided in critical access or rural hospitals following enactment of legislation in 2017, and are authorized to order appropriate lab tests and diagnostic imaging tests in the perioperative and immediate postoperative periods. The APRN SOP, as defined in regulation, includes standards of the national certifying body and "consultation with or referral to medical and other healthcare providers when required by client healthcare needs." Psychiatric and mental health CNPs and certified PCNSs may sign documents for emergency, involuntary commitment through EDs. CNPs are authorized to certify patients to receive therapeutic or palliative benefit from medical use of marijuana.

APRNs are statutorily defined as PCPs and may be credentialed as allied staff for hospital privileges. Admitting privileges are not granted in this authority. Workers' compensation forms recognize CNPs and allow issuance of license plates and cards for the physically disabled. Current law requires a master's degree in nursing and national certification to enter practice.

■ Reimbursement

The 1999 Act to Increase Access to Primary Health Care Services (HP617) requires reimbursement under an indemnity or

managed-care plan for patient visits to an NP or CNM when referred from a PCP, requires insurers to assign separate provider ID numbers to CNPs and CNMs, and allows managed-care enrollees to designate CNPs as their PCP. However, MCOs are not required to credential any physician or CNP if their access standards have been met.

Reimbursement under indemnity plans is mandated for master's-prepared, certified psychiatric/mental health CNSs; no other third-party reimbursement for APRNs is required by law. Some insurance carriers, however, reimburse independent CNPs. Medicaid reimburses in full, on a fee-for-service basis, for services provided by certified family NPs, CPNPs, and CNMs.

■ Prescriptive authority

CNPs and CNMs may prescribe and dispense drugs or devices, including Schedules II, III, IV, and V CSs, in accordance with rules adopted by the BON; approved CNPs and CNMs receive their own DEA numbers. BON rules require CNPs and CNMs to have a pharmacology course and prescribe from FDA-approved drugs related to the nurse's specialty.

CNPs and CNMs may prescribe Schedules II, III, IV, and V CSs and drugs off-label, according to common and established standards of practice. CNPs and CNMs may receive and distribute drug samples included in the formulary for prescription writing.

New statutes passed in 2017 authorize a CRNA to order and prescribe medication during the perioperative and postoperative period. CRNAs may prescribe Schedules III, IIIN, IV, and V CSs only (1) for a supply of not more than 4 days with no refills; and (2) for an individual for whom the CRNA has established a client or patient record at the time of the prescription.

Maryland

www.mbon.org
www.npamonline.org
www.maapconline.org
www.campaignforaction.org/state/maryland

■ Legal authority

The Maryland BON regulates APRN practice. APRNs include CNP (NP or CRNP in statute), CRNA, CNM, and CNS roles. Maryland also recognizes nurse psychotherapists as APRNs (APRN/PMH). NP SOP is independent, defined in statute and regulations, and is in accordance with the Standards of Practice of the American Association of Nurse Practitioners or any other national certifying body recognized by the BON.

Scope and standards of independent practice for NPs are defined in statute and regulations. CRNAs maintain an affirmation of collaboration with the BON containing the name and license number of an anesthesiologist, physician, or dentist; CNPs, CNMs, and CNSs practice independently without a collaborative practice agreement. A master's degree is the minimum required degree to enter practice in Maryland in addition to national board certification.

NPs and CNMs holding a state-controlled dangerous substances registration, registration with the Maryland Medical Cannabis Commission, and are in good standing with the state BON may issue written certification for medical marijuana use to qualifying patients.

■ Reimbursement

All nurses are entitled to private third-party and Medicaid reimbursement for services if they are practicing within their legal SOP. All Medicaid recipients have been assigned to an MCO; CNPs (with the exception of neonatal and acute care) and CNMs have been designated as PCPs and may apply to be placed on a provider panel. Medicaid reimburses at 100% of physician payment.

Recent legislation requires Medicaid to reimburse PCPs for telemedicine services. The law allows due process for APNs listed on managed-care panels; APRNs are not to be arbitrarily denied. The law does not require, however, that an HMO include CNPs on the HMO panel as PCPs. Several commercial insurers reimburse NPs directly; however, reimbursement is generally at a rate of 75% to 85% of a physician's fee schedule.

■ Prescriptive authority

CNPs and CNMs have full prescriptive authority, including for Schedules II, III, IV, and V CSs. The scope of prescriptive authority is defined in statute. CNPs and CNMs are authorized to obtain both federal and state DEA numbers. CNPs are legally authorized to dispense medications in public health settings and student health clinics. Prescription containers are labeled with the CNP or CNM name.

Massachusetts

www.mass.gov/dph/boards/rn
www.mcnpweb.org
www.campaignforaction.org/state/massachusetts

■ Legal authority

The Massachusetts BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP,

CRNA, PCNS, CNS, and CNM roles. Advanced practice R&Rs governing the ordering of tests, therapeutics, and prescribing are promulgated by the BON with concurrence from the BOM; all other areas of SOP are exclusively under the BON. SOP is defined both in statute and regulation.

Massachusetts recognizes APRNs as PCPs; however, state law does not contain "any willing provider" language. Credentialing for hospital privileges varies according to hospital policies. Massachusetts mandates a minimum of a graduate degree for initial (not reciprocal) APRN authorization. National certification is required to enter and remain in practice.

■ Reimbursement

FNPs, PNPs, and adult NPs are reimbursed at 100% of the physician payment rate for Medicaid unless the NP is employed by the hospital in a hospital-based practice. Massachusetts state law mandates reimbursement to NPs, PCNSs, NMs, and nurse anesthetists in accordance with Chapter 302 of the Acts and Resolves of 1994. These include indemnity plans, nonprofit hospital corporations, medical service corporations, and HMOs.

BC/BS, Fallon, and Neighborhood Health Plan credential NPs in private practice settings to receive individual provider numbers. Effective January 2009, all health insurers are required to recognize NPs as PCPs and include them in provider directories for consumer choice.

■ Prescriptive authority

Massachusetts state law provides for prescriptive authority for CNPs, CNMs, CRNAs, and PCNSs, including Schedule II–V CSs. Authorized APRNs must apply to the Massachusetts Department of Public Health for state registration and then apply for a federal DEA number. CNPs, CRNAs, and PCNSs must establish written guidelines developed in collaboration with the nurse and supervising physician, which includes a defined mechanism to monitor prescribing practices and must designate a physician who will provide medical direction for prescriptive practice as is customarily accepted in the specialty area.

Initial prescription of Schedule II CSs requires review within 96 hours. Authorized APRNs can request, receive, and dispense pharmaceutical samples. The prescription pad of the CNP, CRNA, and PCNS includes the name of the supervising physician and the APRN; however, the authorized APRN signs the prescription.

Michigan

www.minurses.org

www.micnp.org

www.campaignforaction.org/state/michigan

■ Legal authority

The Michigan BON grants legal authority to practice and regulates the practice of APRNs through certification issued to them as an RN. Newly defined in statute, APRNs include RNs who have been granted a specialty certification by the BON in the following roles: CNP, CNS, and CNM. CRNAs (nurse anesthetist in statute) are recognized by the BON and granted specialty certification but are not categorized as APRNs in statute. According to the Michigan Council of Nurse Practitioners (although no statute exists requiring supervision or collaboration to practice with the exception of prescriptive authority), the state has interpreted NP practice as “supervised” due to their ability to “diagnose,” which is defined as the practice of medicine.

The certification recognizes the additional training and completion of a certification program that enables the RN to handle tasks of a more specialized nature that are delegated to him or her. APRN SOP is not defined within statute, and thus, is considered the RN SOP and what tasks can be delegated by another licensee, which is typically a physician.

Under some HMOs and systems, CNPs are recognized as PCPs. Michigan does not have “any willing provider” language in statute. Michigan statute does not specifically authorize APRNs to admit patients or hold hospital privileges; however, this depends on the institution, and hospitals generally grant these privileges. APRNs are required to have a graduate degree in nursing and national board certification to enter practice.

■ Reimbursement

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

■ Prescriptive authority

APRNs are authorized to prescribe nonscheduled prescription drugs; prescribing Schedules II, III, IV, and V CSs is authorized as a delegated act of a physician and must include the APRN and physician names and DEA numbers.

APRNs may order, receive, and dispense nonscheduled complementary starter dose drugs independently; however, delegation by a physician is required to order, receive, and dispense complementary starter doses of Schedules II, III, IV, and V CSs. Prescription labels include both the APRN and physician name.

Minnesota

www.nursingboard.state.mn.us

www.mnnp.org

<https://mnaprnc.enpnetwork.com/>

www.campaignforaction.org/state/minnesota

■ Legal authority

The Minnesota BON grants APRNs the authority to practice through licensure and regulates their practice. APRNs include CNP, CNS, CNM, and CRNA roles. APRNs have independent practice in Minnesota. CNPs and CNSs are required to complete a “postgraduate practice” period of at least 2,080 hours within the context of a collaborative agreement with a physician or APRN within a hospital or integrated clinical setting where APRNs and physicians work together to provide patient care.

CRNAs and CNMs do not have a postgraduate practice requirement. APRN SOP is defined in statute and must be consistent with their education and certification. APRNs are not statutorily prohibited from admitting patients and holding hospital privileges. Minnesota APRNs are licensed by the BON following completion of an accredited graduate-level APRN program and national certification by a recognized APRN certifying organization.

■ Reimbursement

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

■ Prescriptive authority

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

Mississippi

www.msnb.ms.gov/Pages/Home.aspx

www.msnurses.org

www.campaignforaction.org/state/mississippi

■ Legal authority

The Mississippi BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP, CNS, CNM, and CRNA roles. CNPs, CRNAs, and CNMs practice in a collaborative relationship with physicians in Mississippi. The collaborating physicians’ practice must be compatible with the CNP’s practice. APRNs must practice according to a BON–approved protocol agreed on by the APRN and physician. Practicing in a site not approved by the BON (with a physician not approved by the BON or according to a protocol not approved by the BON) is in violation of the NPA R&Rs.

SOP is defined and regulated by the BON. CNPs are statutorily recognized as PCPs; however, Mississippi law does not contain “any willing provider” language. APRNs are legally authorized to admit patients and hold hospital privileges. APRNs are required to have a master’s degree or higher in nursing, nurse anesthesia, or midwifery, and must be nationally certified to enter practice.

■ Reimbursement

Medicaid reimbursement is available to APRNs at 90% of the physician payment. Insurance law specifies that whenever an insurance policy, medical service plan, or hospital service contract provides for reimbursement for any service within the SOP of a CNP working under the supervision of a physician, the insured shall be entitled to reimbursement whether the services are performed by the physician or NP. Reimbursement is increased to 100% for CNPs who provide healthcare services after 5:00 p.m.

■ Prescriptive authority

CNPs and CNMs have full prescriptive authority, including Schedules II, III, IV, and V CSs, based on the standards and guidelines of the CNP or CNM’s national certification organization and a BON–approved protocol that has been mutually agreed on by the CNP or CNM and qualified physician. The protocol must outline diagnostic/therapeutic procedures and categories of pharmaceutical agents that may be ordered, administered, dispensed, and/or prescribed for patients with diagnoses identified by the CNP.

CNPs may receive and distribute prepackaged medications or samples of noncontrolled substances for which the NP has prescriptive authority. Schedules II, III, IV, and V CSs may be prescribed pursuant to

additional BON rules and regulations: the NP must have a DEA number, completed a BON-approved educational program, and submitted a “controlled substance prescriptive authority protocol” to the BON. CNMs and CRNAs may order CSs within a licensed healthcare facility using BON-approved protocol or practice guidelines.

Missouri

www.pr.mo.gov/nursing.asp

www.missourinurses.org

www.campaignforaction.org/state/missouri

■ Legal authority

The Missouri BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP, CNS, CNM, and CRNA roles. APRNs practice in collaboration with physicians in Missouri. Collaborative practice includes written agreements, written protocols, or written standing orders. R&Rs define the Collaborative Practice (CP) rule.

Three focus areas in the CP rule include geographic areas to be covered, methods of treatment that may be covered by CP arrangements, and requirements for review of services provided pursuant to a CP arrangement. A written CP arrangement with a physician is not needed when the APRN is performing nursing acts consistent with the APRN’s skill, training, education, and competence.

A CP arrangement may be indicated to perform physician-delegated medical acts within the mutual SOP of the physician and APRN and consistent with the APRN’s skill, training, education, and competence. CRNAs practice under the direction of the surgeon, anesthesiologist, dentist, or podiatrist, and are not required to have a collaborative practice arrangement. Individuals are recognized by their specific clinical nursing specialty area as a CNP, CNS, CNM, or CRNA, which delineates their title and SOP as APRNs in R&Rs.

When practicing outside their recognized clinical nursing specialty, individuals must practice and title as RNs only. Missouri law does not recognize APRNs as PCPs and does not contain “any willing provider” language. Additionally, APRNs are not legally authorized to admit patients or hold hospital privileges. NPs are required to hold a graduate degree in nursing and national certification to enter practice in Missouri.

■ Reimbursement

Current law states, “Any health insurer, nonprofit health service plan, or HMO shall reimburse a claim for services provided by an APRN, if such services are within the SOP of

such a nurse.” Medicaid reimbursement is made to APRNs enrolled as Missouri Medicaid fee-for-service providers and Medicaid-enrolled APRNs associated with a federally qualified healthcare or rural healthcare facility or both.

Medicaid reimbursement is limited to services furnished by enrolled APRNs who are within the SOP allowed by federal and state laws and inpatient or outpatient hospital/clinical services furnished to the extent permitted by the facility. Reimbursement for services provided by APRNs is at the same rate and subject to the same limitations as physicians.

■ Prescriptive authority

Prescriptive authority for CNPs, CNSs, and CNMs includes prescription drugs/devices and Schedules III, IV, and V CSs as delegated by a physician pursuant to a written CP arrangement. APRNs with a CP arrangement and CS prescriptive authority are authorized to prescribe hydrocodone-containing compounds from Schedule II CSs. Legislation passed in 2018 authorizes prescriptive authority for buprenorphine up to a 30-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the collaborating physician.

CNPs, CNSs, and CNMs must complete 1,000 hours of postgraduate clinical experience in the APRN role prior to application for CS authority. CRNAs have prescriptive authority but are prohibited from prescribing CSs. Hydrocodone-containing Schedule II and all Schedule III opioid prescriptions will be limited to a 120-hour supply with no refills.

Delivery of such APRN healthcare services shall be within the APRN’s advanced clinical nursing specialty area and a mutual SOP with the physician in addition to being consistent with the individual’s skill, training, education, and competence. APRNs may receive and dispense samples within their prescriptive authority. A state Bureau of Narcotics and Dangerous Drugs number, as well as a DEA number, is required. Prescriptions written by an NP are labeled with both the collaborating physician’s and NP’s names.

Montana

www.bsd.dli.mt.gov/license/bsd_boards/nur_board/board_page.asp

<https://mntnurses.nursingnetwork.com>

www.campaignforaction.org/state/montana

■ Legal authority

The Montana BON grants APRNs authority to practice and regulates their practice. APRNs include CNP, CNS, CNM, and CRNA roles.

APRNs practice independently after completing specific curriculum requirements and a national certifying exam by a BON-recognized national certifying body.

According to the Montana BON, all APRNs are expected to engage in ongoing competence development per Rule ARM 24.159.1469. APRN SOP is defined in Rule ARM 24.159.1405 and 24.159.1406. APRNs are legally authorized to admit patients and hold hospital privileges; however, this varies according to the rules and bylaws of each hospital.

APRNs licensed after 2008 must have a graduate-level degree or postgraduate certificate from an accredited APRN program and hold national certification to enter practice. APRNs seeking licensure by endorsement from another state must hold national certification among other requirements. All APRNs must maintain a quality assurance plan as part of the APRN competence development as defined.

■ Reimbursement

Medicaid reimburses APRNs at 85% of physician payment. Montana law requires indemnity plans to reimburse APRNs for all areas and services for which a policy would reimburse a physician; however, HMOs are not included in the indemnity insurers’ law, and 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 prescriptive authority must apply for recognition by the BON. APRNs with prescriptive authority are independently authorized to prescribe all medications, including Schedules II, III, IV, and V CSs using their own DEA number and are permitted to request, receive, and dispense drug samples. Renewal of prescriptive authority occurs every 2 years, including an affirmation of a minimum of 12 contact hours of accredited education in pharmacology, pharmacotherapeutics, and/or clinical management of drug therapy.

Nebraska

<http://dhhs.ne.gov/publichealth/pages/crNursingHome.aspx>

www.nebraskanp.org

www.campaignforaction.org/state/nebraska

■ Legal authority

The Nebraska APRN Board grants APRNs the authority to practice and regulates their practice. APRNs include CNP (NP in statute), CNS, CNM, and CRNA roles. NPs enjoy FPA

following a 2,000-hour transition to practice period supervised by an experienced physician or NP, as defined. An NP's SOP is defined in statute and includes illness prevention, diagnosis, treatment, and management of common health problems and acute and chronic conditions. CNMs continue to practice in collaboration with physicians as specified within the integrated practice agreement (IPA).

CRNAs are authorized to determine and administer total anesthesia care as described in consultation and collaboration with a licensed physician or osteopathic physician. An IPA is not required for CRNA practice. CNS SOP is defined in statute and includes health promotion and supervision, illness prevention, and disease management within a selected clinical specialty. Nebraska requires a master's or doctorate degree in nursing, proof of professional liability insurance, and 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 providers. In 2008, BC/BS began reimbursing APRNs at 85% of the physician rate. Medicaid reimburses NPs at 100% of the physician rate. Legislation passed in 2016 authorizes board-certified primary care NPs or those NPs who specialize in family practice, internal medicine, or pediatrics to be listed as a Direct Provider and be reimbursed for services under the Direct Primary Care Agreement Act.

■ Prescriptive authority

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

Nevada

<https://nevadanursingboard.org/www.nvnurses.org>

www.campaignforaction.org/state/nevada
www.nonl.org

■ Legal authority

The Nevada BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP (NP in statute), CNS, CNM, and CRNA roles. APRNs who have

been practicing for 2 years (or 2,000 hours) are granted FPA. New graduates or those practicing for less than 2 years (or 2,000 hours) are required to complete a transition to practice period, which includes a formal, written collaborative agreement with a physician with written protocols (only if Schedule II CSs are prescribed).

APRN SOP is defined in the NPA and includes the nationally established scope and standards for the APRN role and global signature authority. APRNs are not recognized as PCPs under Nevada state law; however, they are legally authorized to admit patients to the hospital and hold hospital privileges. If the applicant completed an APRN program after June 1, 2005, the applicant must hold a master's degree in nursing. Applicants requesting APRN licensure after July 14, 2014, must hold a master's or doctorate degree in nursing or related health field and must hold national certification.

■ Reimbursement

APRNs are recognized by insurance companies and receive third-party reimbursement.

■ Prescriptive authority

BON-authorized APRNs may prescribe Schedules II, III, IV, and V CSs, poisons, and dangerous drugs and devices when authorized by the BON and a certificate of registration is obtained from the BOP. A collaborative agreement and protocols with a physician are only required for APRNs with less than 2 years or 2,000 hours of experience and only if prescribing Schedule II CSs.

APRNs register for their own DEA numbers. APRNs may pass a BON exam for dispensing and, after passing the exam with BON approval, apply to the BOP for a dispensing certificate. Samples are not considered "dispensing," and APRNs with prescriptive authority may receive and distribute samples without having dispensing authority.

New Hampshire

www.state.nh.us/nursing
<http://nhnpa.enpnetwork.com>
www.campaignforaction.org/state/new-hampshire

■ Legal authority

The New Hampshire BON grants APRNs authority to practice and regulates their practice. APRNs include CNP, CNM, and CRNA roles. APRNs have FPA with their SOP defined in statute and do not require physician collaboration or supervision. APRNs are statutorily recognized as PCPs in New

Hampshire; however, state law does not include "any willing provider" language. APRNs may admit patients and hold hospital privileges per individual institutional policy. The minimum academic degree required to enter 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 may reimburse APRNs when the insurance policy provides any service that may be legally performed by the APRN and such service is rendered. APRNs are recognized as PCPs by all HMOs in the state. Medicaid reimburses APRNs at 100% of physician payment.

■ Prescriptive authority

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

The passage of legislation in 2016 requires all prescribers who possess DEA registration to register with the PDMP and shall complete and submit verification of 3 contact hours (of the 5 that are already required for renewal and reinstatement) of regulatory board-approved online CE or pass an online exam in the area of pain management, opioid prescribing, addiction disorder, or a (or a course combining two or more of these areas as a condition) as a condition for initial licensure and license renewal or reinstatement. Prescription labels are marked with the APRN's name.

New Jersey

www.njconsumeraffairs.gov/nur/Pages/default.aspx
www.njsna.org
www.campaignforaction.org/state/new-jersey

■ Legal authority

The New Jersey BON grants APRNs authority to practice and regulates their practice. APRNs are defined as APNs in the state of New Jersey and include CNP, CNS, and CRNA roles. CNMs are regulated by the New Jersey BOM. APNs practice in collaboration with physicians and are required to have a joint protocol with the collaborating physician for prescribing drugs and devices only. SOP for APNs is defined in statute. APNs are recognized as PCPs.

However, New Jersey does not have “any willing provider” language in statute. APNs are legally authorized to admit patients and hold hospital privileges, but this is not defined by statute or regulation. Privileges are determined through the credentialing/privileging process of individual healthcare institutions. APN applicants must be master’s prepared in nursing, and national board certification is required to enter practice in New Jersey.

■ Reimbursement

Private health plans, including Medicaid managed-care plans, are permitted to credential APNs as PCPs but not required to recognize or reimburse them. After the APN has been credentialed by or has obtained a provider number from these insurers, the APN is recognized as an Independently Licensed Practitioner/Provider (ILP) and can be directly reimbursed by Medicare, New Jersey Medicaid, NJ FamilyCare, United Health-care, and other Medicaid HMOs, including Cigna, Great West, Health Net, Amerigroup/Choice, QualCare, and Oxford.

Aetna and Horizon BC/BS and some other Horizon MCOs will only credential and reimburse APNs who work in physician practices—not as ILPs providing primary care. Both Horizon and Aetna have fairly consistently credentialed and directly reimbursed psychiatric APNs. Note that direct reimbursement to APNs is also provided by the Civilian Health and Medical Program (uniformed service members and their families). If APNs are credentialed and directly reimbursed by private insurers, it is generally at 85% of the physician rate, mirroring Medicare.

■ Prescriptive authority

APNs credentialed by the BON have full prescriptive authority, including Schedules II, III, IV, and V CSs, in accordance with a joint protocol, which has been established by the APN and the collaborating physician. The joint protocol is required for prescribing drugs and devices only and is not a collaborative agreement for general practice.

To prescribe CSs, APNs must have both a state-controlled dangerous substance (CDS) number/federal DEA number and have modified the joint protocol to indicate whether prior consultation with the collaborating physician is necessary before initiating CDS prescriptions. In addition to basic pharmacology education requirements required for APN certification, all APNs must complete a one-time, 6-hour course in CS prescribing, including addiction prevention and management by an approved/accredited

organization. APNs are authorized to request, receive, and dispense pharmaceutical samples.

New Mexico

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

■ Legal authority

The New Mexico BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP, CNS, and CRNA roles. CNPs practice independently without physician supervision or collaboration requirements and their SOP is defined in statute 61.3.23.2 of Chapter 61, Article 3 of the New Mexico Statutes. APRNs are statutorily recognized as PCPs when providing care within their SOP in several areas of New Mexico law; however, New Mexico does not have “any willing provider” language contained within the statutes. CNPs are legally authorized to hold admitting and hospital privileges and can serve as “acute, chronic, long-term, and end-of-life healthcare providers.” A master’s degree in nursing or higher and national board certification are required to enter practice as a CNP.

CRNAs seeking initial licensure must be at the master’s level or higher. CRNAs work in collaboration with a physician and have prescriptive authority, including Schedules II, III, IV, and V CSs. CNSs must be master’s prepared and certified by a national certifying nursing organization. CNSs “make independent decisions,” have “prescriptive authority,” including Schedules II, III, IV, and V CSs, and can distribute prepackaged drugs. CNMs are regulated by the Department of Health and are recognized as PCPs in statute.

■ 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, and CNPs continue to meet resistance in being listed as PCPs with some companies. FNPs and PNP receive Medicaid reimbursement at 85% of the physician payment. All three of the managed-care groups contracted to provide Medicaid coverage have contracts with NPs.

■ Prescriptive authority

CNPs have full, independent prescriptive authority, including Schedules II, III, IV, and V CSs. BON prerequisites to prescribe CSs include experience with prescription writing, a state-CS 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 prescriptive authority during a 400-hour preceptorship before they can prescribe independently.

CNMs have prescriptive authority pursuant to the rule-making authority of the Department of Health. CRNAs who meet prescriptive authority requirements may collaborate independently and prescribe and administer therapeutic measures, including dangerous drugs and CSs, within emergency procedures, perioperative care, or perinatal care environments. CNPs and CNSs with prescriptive authority may distribute dangerous drugs and Schedules II, III, IV, and V CSs that have been prepared, packaged, or prepackaged by a pharmacist or pharmaceutical company. Prescription labels are marked with the APRN’s name where appropriate.

New York

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

■ Legal authority

New York’s NPA is codified in Education Law Article 139. The New York State Education Department certifies CNPs (NP in statute) to practice in defined areas, including family, gerontology, neonatology, obstetrics, oncology, pediatrics, perinatology, psychiatry, school health, women’s health, holistic, and palliative care. The term APRN is not defined in New York statutes or regulation. NPs diagnose illnesses and physical conditions and perform therapeutic and corrective measures within the specialty area of practice in which the NP is certified.

New York’s NPA requires all NPs with less than 3,600 hours of practice experience to practice pursuant to a written practice agreement with a collaborating physician. NPs with more than 3,600 hours of qualifying practice experience can opt to: practice in accordance with a written practice agreement with a collaborating physician, or practice and have collaborative relationships with one or more qualified physicians or a New York State Department of Health licensed hospital, long-term-care facility, or clinic. Collaborative relationships are when an NP communicates by phone, in person, in writing, or electronically with a qualified physician to exchange information to provide comprehensive care or to make referrals as necessary.

NPs are legally authorized to hold admitting privileges. A master’s degree in

nursing is required to enter practice; however, national board certification is not required. CNMs are not regulated or recognized by the BON but must complete a master's or higher degree program in midwifery or a related field that is accredited by the American College of Nurse-Midwives Division of Accreditation.

■ Reimbursement

In New York, most NPs have NPIs issued by the US Center for Medicaid and Medicare Services. In New York, NPs can form and own private practices that provide NP services. NPs qualify as participating providers in New York's Medicaid program, Medicare program, and a variety of commercial managed-care and insurance plans.

■ Prescriptive authority

NPs are eligible for full prescription privileges if they complete the coursework in prescription writing and record keeping required in New York State. NPs can prescribe or order medications, including Schedules II, III, IV, and V CSs, diagnostic tests, imaging studies, lab tests, and medical devices.

NPs can issue non-patient-specific orders and protocols (standing orders) to be executed by registered professional nurses. NPs may dispense medications to their patients. Midwives are authorized to prescribe and administer drugs, immunizing agents, diagnostic tests, devices, and order lab tests limited to the practice of midwifery; they may dispense pharmaceutical samples packaged or prepackaged by a pharmacist or pharmaceutical company.

North Carolina

www.ncbon.com

www.ncnurses.org

www.campaignforaction.org/state/north-carolina

■ Legal authority

In North Carolina, the term *APRN* is defined in a regulation that includes CNP, CNS, CNM, and CRNA roles. A joint subcommittee of the North Carolina BON and the North Carolina Medical Board grant CNPs the authority to practice and regulate their practice. Both CRNAs and CNSs are regulated solely by the BON. CNMs are regulated by the Midwifery Joint Committee. Eligibility requirements for all APRN roles include a current unencumbered RN license, graduate education in one of the four recognized APRN roles, and initial and ongoing national certification in their population focus as an APRN.

CNPs legally practice under a supervisory relationship with a primary supervising physician (PSP). The parameters of the CNP's practice are operationalized through a CPA, which must describe the arrangement for CNP-PSP continuous availability to each other for the ongoing supervision, consultation, collaboration, referral, and evaluation of care provided by the NP. The CPA also includes the drugs, devices, medical treatments, tests, and procedures that may be prescribed, ordered, and performed by the CNP as well as a plan for emergency services.

During the first 6 months of CNP practice with a new PSP, monthly Quality Improvement Process meetings are required, then every 6 months thereafter. These meetings must be documented with CNP and PSP signatures. State law does not prohibit CNPs from having admitting privileges and hospital privileges; however, these are granted on a facility-by-facility basis. APRNs are authorized to form professional corporations or professional limited liability companies for providing medical services.

■ Reimbursement

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

■ Prescriptive authority

CNPs and CNMs have full prescriptive authority, including Schedules II, III, IV, and V CSs that are identified in their CPA. Dispensing may be done under specific conditions and if a dispensing license has been obtained. CNPs/CNMs may provide refills consistent with CS laws and regulations, which stipulate that prescriptions for Schedule II CSs cannot be refilled.

A new prescription must be issued. Adoption of the 2017 Strengthen Opioid Misuse Prevention (STOP) Act limits prescribers to a 5-day supply of any "targeted controlled substance" (G.S. 90-90[1] or [2] or G.S. 90-91[d]) upon initial consultation and treatment for acute pain, and a 5-day supply of any "targeted controlled substance" for postoperative acute pain relief for use following a surgical procedure, with some exceptions.

The STOP Act further requires the CNP to consult with a supervising physician prior to prescribing some certain Schedule II and

Schedule III CSs labeled "targeted controlled substances" in a pain management clinic or where pain management services are advertised when use of the targeted CS is expected to exceed 30 days. CNPs must consult with the physician at least once every 90 days thereafter.

CNPs and CNMs with CSs in their collaborative practice agreements must obtain DEA registration (in addition to their approval number issued at the time of their approval as CNPs/CNMs), and the supervising physician(s) shall possess the same schedule(s) of CSs as the CNP's DEA registration. CNPs are authorized to hand out, free of charge, starter doses or packets of prescription drug samples received from a prescription drug manufacturer in compliance with the Prescription Drug Marketing Act. CRNAs and CNSs do not have prescriptive authority in North Carolina.

North Dakota

www.ndbon.org

www.ndnpa.org

www.campaignforaction.org/state/north-dakota

www.ndna.org

■ Legal authority

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

■ Reimbursement

FNPs, PNPs, and CNMs receive Medicaid reimbursement at 75% of the physician rate and CNMs at 85% of the physician rate. BC/BS reimburses CRNAs, CNMs, CNSs, and NPs based on the lesser of the provider's billed charges or 75% of the BC/BS physician payment system in effect at the time the services are rendered. Legislation passed in 2009 granted an NP authority to be a PCP within the Medicaid system. Any certified NP is eligible for a Medicaid provider number. State law authorizes reimbursement for health services provided in the scope of licensure by nurses with advanced licensure and mental health in their SOP.

APRNs are statutorily recognized as PCPs. Providers practicing more than 20

miles from Williston, Dickson, Minot, Bismarck, Jamestown, Devils Lake, Grand Forks, Wahpeton, and Fargo shall be reimbursed the lesser of provider's billed charges or 85% of the BC/BS physician payment system(s) in effect at the time services are rendered.

■ Prescriptive authority

Authorized APRNs may prescribe, administer, sign for, and dispense OTC, legend, and CSs and procure pharmaceuticals, including sample legend drugs and Schedules II, III, IV, and V CSs. For prescriptive authority, the APRN must apply to the BON and meet the requirements outlined in North Dakota Administrative Code section 54-05-03.1-09. APRNs with prescriptive authority may apply for a DEA number.

Ohio

www.nursing.ohio.gov

www.oaapn.org

www.campaignforaction.org/state/ohio

■ Legal authority

The Ohio BON grants APRNs the authority to practice and regulates their practice. The BON issues APRN licenses with the designation of CNP, CRNA, CNM, or CNS. Legal authority to practice requires a CP arrangement (standard care arrangement in statute) between a physician or podiatrist and an APRN-CNP or APRN-CNS, and between a physician and an APRN-CNM in the form of a standard care arrangement (practice agreement). Psychiatric/mental health CNPs and CNSs may only enter a CP with a physician practicing in psychiatry, pediatrics, or family practice/primary care.

CRNAs are required to practice with a supervising physician. The SOP for CNPs is defined in statute ORC 4723.43. CNPs are statutorily recognized as providing preventive and primary care services, services for acute illnesses, and evaluation and promotion of patient wellness within the nurse's specialty, consistent with the nurse's education and certification.

APRNs are authorized to admit patients to a hospital if the APRN has a standard care arrangement with a collaborating physician who is a member of the hospital's medical staff. Applicants for APRN licensure must have a master's or doctoral degree in nursing or a related field that qualifies the individual to sit for the national certifying exam and hold national certification to enter practice.

■ Reimbursement

Ohio's Medicaid program recognizes CNPs certified in family, adult, acute care, geriatric, neonatal, pediatric, and women's

health/obstetrics. It also recognizes CNMs, CRNAs, and CNSs certified in gerontology, medical-surgical, and oncology nursing specialties. MCOs vary on empanelment. There are no legislative restrictions for an APN to be listed on managed-care panels; insurance companies are statutorily mandated to reimburse CNMs. Workers' compensation continues to reimburse CNPs, CRNAs, and CNSs. (The BON does not maintain information regarding reimbursement.)

■ Prescriptive authority

Ohio state law includes prescriptive authority within the APRN license issued to CNPs, CNMs, and CNSs including Schedules II, III, IV, and V CSs under rules and in collaboration with a physician. APRN-CNPs, APRN-CNMs, and APRN-CNSs register with the Ohio Automated Rx Reporting System and access the database information as required.

APRNs prescribe based upon an exclusionary formulary recommended by the Interdisciplinary Committee on Prescriptive Governance (CPG) and adopted by the BON. The exclusionary formulary states that a CNP, CNS, and CNM shall not prescribe any drug in violation of federal or Ohio law. By statute, the prescriptive authority of a CNP, CNS, or CNM shall not exceed the prescriptive authority of the collaborating physician or podiatrist. APRNs are permitted to prescribe newly released drugs if they are not of a type that is prohibited by the exclusionary formulary. The CPG will review newly released drugs to determine if they should be excluded under the formulary.

APRNs who wish to prescribe drugs for off-label use must include parameters for off-label use in the standard care arrangement. The prescribing of Schedule II CSs is limited to those prescriptions issued from specific locations and programs recognized in Ohio nursing law, and as consistent with the APRN's standard care arrangement. Limitations are also placed on APRNs' prescribing of opioids for the treatment of acute pain.

APRNs who are not practicing in a location or program recognized in law are limited in their Schedule II CS prescribing to the care of terminally ill patients after a physician has initiated and only for a 72-hour period. DEA registration is required. APRNs with prescriptive authority may request, receive, sign for, and personally furnish sample medications. All samples of medications that are personally furnished by the APRN must be consistent with the APRN's scope and not excluded by state or federal law.

Oklahoma

www.lsb.state.ok.us

www.ok.gov/nursing

www.campaignforaction.org/state/oklahoma

■ Legal authority

The Oklahoma BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP, CNS, CNM, and CRNA roles. CNPs function independently except for prescriptive authority, which requires supervision by a physician. APRNs practice within an SOP as defined by the NPA. The SOP for a CNP is further identified in specialty categories that delineate the population served, such as adult gerontology, family/individual across the lifespan, and so forth. CNSs must hold a master's degree in nursing, and CNPs/CNSs must be nationally board certified to enter practice.

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. Effective January 1, 2016, APRN applicants must have completed an accredited graduate-level APRN education program in at least one of the following population foci: family/individual across the lifespan, adult gerontology, neonatal, pediatrics, women's health/gender-related, or psychiatric/mental health.

■ Reimbursement

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

■ Prescriptive authority

The BON regulates optional prescriptive authority for CNPs, CNSs, and CNMs, which includes Schedules III, IV, and V CSs. Physician supervision is required for prescriptive authority. Prescribing parameters include the following: drugs must not be on the exclusionary formulary approved by the BON; must be within the CNP, CNM, and CNS SOP; include Schedules III, IV, and V CSs (30-day supply) if state Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD) and DEA registrations are obtained; and include signing to receive drug samples. A CRNA, regulated by the BON, may order, select, obtain, and administer drugs only during the perioperative or peribstretical period. CRNAs must obtain state OBNDD and DEA registrations to order Schedules II, III, IV, and V CSs.

Oregon

www.oregonrn.org

www.oregon.gov/OSBN

www.campaignforaction.org/state/oregon

■ Legal authority

The Oregon BON grants FPA to and regulates CNPs (NP title in regulation; CNMs are a category of NP), CNSs, and CRNAs. Nurses in all three categories of advanced practice must be credentialed with a certificate by the BON. "APRN" is not a protected title in the Oregon NPA. SOP is defined in regulation, Division 50, 52, and 54 of the NPA and 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 a doctoral degree in nursing is required for the CNS entry into practice and is also required for the NP or CRNA educated after specific dates (see regulations for further information). Since 2011, national board certification has been required to enter practice. Only physicians can authorize medical marijuana use.

■ Reimbursement

NPs are entitled by law to reimbursement by third-party payers. APRNs are designated as PCPs on several HMO and managed-care plans. Medicaid reimburses NPs for services within their SOP at the same rate as physicians. Statutory authority provides full payment parity from private insurers for NPs in independent practice and when billing through a clinic or practice. Numerous administrative rules and statutes include NPs, such as those for special education physical exams (Department of Education) and chronically ill and disabled motorist exams (Department of Motor Vehicles).

■ Prescriptive authority

Regulation of prescriptive authority is under the sole authority of the BON and is defined in Division 56 of the NPA. Oregon has legislated independent or plenary authority for NPs and CNSs to prescribe, so NPs and CNSs are able to obtain DEA numbers for Schedules II, III, IV, and V CSs. NPs and CNSs with prescription-writing authority may receive and distribute prepackaged complementary drug samples. NPs and CNSs may apply to the BON for unencumbered drug-dispensing authority. NPs do not have authority to prescribe under the physician-assisted suicide law.

CRNAs are authorized to select, obtain, order, and administer preanesthetic medications, anesthetic agents, and

medications necessary for implementing and managing pain management techniques during the postanesthesia period pursuant to ORS 851-052-0010. CRNAs may apply to the BON for limited prescriptive authority.

Pennsylvania

www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Nursing/Pages/default.aspx

www.pacnp.org

www.campaignforaction.org/state/pennsylvania

■ Legal authority

The Pennsylvania BON grants CRNPs and CNSs authority to practice and regulates their practice. *APRN* is not defined in statute or regulation. A CRNP performs the expanded role in collaboration with a physician, which is defined as a process in which a CRNP works with one or more physicians to deliver healthcare services within the scope of the CRNP's expertise.

The collaborative agreement is a signed, written agreement between the CRNP and a collaborating physician in which they agree to the details of their collaboration, including the elements in the definition of collaboration. The CRNP's SOP is defined in statute and regulation. CRNPs are recognized as PCPs by the Department of Human Services and many insurance companies, but some managed-care companies do not recognize CRNPs as PCPs.

The Pennsylvania Department of Health Regulations authorizes a hospital's governing body to grant and define the scope of clinical privileges to individuals with advice of the medical staff. CRNPs must have a master's degree and pass a national certification exam to enter practice. The BON does not track, monitor, or license CRNAs; the BOM licenses and regulates CNMs.

■ Reimbursement

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

■ Prescriptive authority

The BON confers prescriptive authority, including Schedules II, III, IV, and V CSs, 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, not from a prohibited drug category, and conforms with regulations. The CRNP may write a prescription for a Schedule II CS for up to a 30-day supply.

CRNPs may prescribe Schedules III and IV CSs for up to a 90-day supply; Schedule V is not restricted. CRNPs are authorized to request, receive, and dispense pharmaceutical sample medications. Prescription blanks must include the name, title, and Pennsylvania certification number of the CRNP.

Rhode Island

www.health.ri.gov/for/nurses

<http://npari.enpnetwork.com>

www.campaignforaction.org/state/rhode-island

■ Legal authority

The Rhode Island BON grants APRNs FPA and regulates their practice. APRNs include CNP, CNS, and CRNA roles. CNMs are licensed and regulated under separate R&Rs and not regulated by the BON. SOP is defined within the NPA. CNPs are statutorily recognized as PCPs in Rhode Island by the Medicaid managed-care program.

Nothing prohibits hospitals from granting admitting and hospital privileges to providers; however, privileging is granted by the facilities based upon individual policies. APRNs are considered licensed independent practitioners in this state. The minimum degree to enter practice for all APRNs is completion of a graduate or postgraduate-level APRN program and national board certification (certain exceptions apply).

■ Reimbursement

State law allows for direct reimbursement of PCNSs and CNMs. PCNSs practicing in collaboration with or employed by a physician receive third-party reimbursement; there is no collaborative or supervisory language in the statute as it pertains to CNPs. United Healthcare has begun to empanel NPs, and the Neighborhood Health Plan fully empanels CNPs as PCPs. The RiteCare Program (managed-care program for persons eligible for Medicaid) allows CNPs and CNMs to serve as PCPs. CRNAs receive third-party reimbursement for

services under the supervision of an anesthesiologist or dentist.

■ Prescriptive authority

With the passage of S614 in 2013, APRNs are granted independent prescriptive authority, including authority to prescribe, order, procure, administer, dispense, and furnish OTC, legend, and CSs (General Laws in Chapter 5-34, Section 5-34-49) within their APRN role and population focus. CNPs may also be authorized to apply to prescribe Schedules II, III, IV, and V CSs. CRNA, CNS, and APRNs in mental health prescribe pursuant to Chapter 5-34, Section 5-34-49 (e), (f), and (g).

South Carolina

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

www.scnurses.org

www.campaignforaction.org/state/south-carolina

■ Legal authority

The South Carolina BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP, CNS, CNM, and CRNA roles. APRNs must have a collaborative relationship with a physician and may perform “delegated medical acts” in addition to nursing acts as defined by the BON. Delegated medical acts may be performed by NPs, CNSs, and CNMs pursuant to an approved written protocol between the nurse and physician and are defined as “additional acts delegated by the physician that include formulating a medical diagnosis and initiating, continuing, and modifying therapies, including prescribing drug therapy under approved written protocols.”

NPs, CNSs, and CNMs who manage delegated medical aspects of care must have a supervising physician who can be accessed by electronic/telephonic means and operate within the “approved written protocols.” APRNs are legally authorized to admit patients to a hospital and hold hospital privileges; however, this is left up to the individual agency. APRNs must hold a doctorate, postmaster’s certificate, or a minimum of a master’s degree in nursing and national board certification in an advanced practice nursing specialty to enter practice.

■ Reimbursement

All NPs, regardless of specialty, may apply for an NPI number, are paid 85% of the physician rate, and are recognized as PCPs. The State Health and Human Services Finance Commissioner requires that NPs have current, accurate, and detailed

treatment plans. Approximately 23 payers recognize, enroll, and directly reimburse APRNs for services provided. Dr. Stephanie Burgess is the first APRN to sit on the advisory board for State Health and Human Services Board in South Carolina, while the rest of the Board consists of physicians.

■ Prescriptive authority

NPs, CNSs, and CNMs have prescriptive authority, including for Schedules III, IV, and V CSs, and prescribe according to practice agreement/protocol within the specialty area of the APRN. CRNAs are not required to obtain prescriptive authority to deliver anesthesia care; however, CRNAs practice pursuant to approved written guidelines with a supervising physician, dentist, or medical staff. The BON issues an ID number to the nurse authorized to prescribe. State law requires prescriptions by NPs be signed by the NP, contain the NP’s BON-assigned prescriber 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 Schedules III, IV, and V CSs.

South Dakota

<http://doh.sd.gov/Boards/Nursing>

www.npasd.org

www.campaignforaction.org/state/south-dakota

■ Legal authority

The South Dakota BON regulates and licenses APRNs. The term *APRN* is defined in statute and includes the CNP, CNS, CNM, and CRNA roles. CNMs and CNPs practice full scope without a collaborative agreement after verifying completion of a minimum of 1,040 hours of practice as a licensed CNM or CNP. Nurses who cannot verify licensed practice hours are required to submit a collaborative agreement with a South Dakota licensed physician, CNM, or CNP to meet the requirement; when the minimum hours are met, the collaborative agreement is retired.

CRNAs and CNSs are required to collaborate with a physician; no written agreement or on-site supervision is required. CRNAs and CNSs do not have prescriptive authority, and CNSs must collaborate before ordering durable medical equipment or therapeutic devices. All APRNs may be granted hospital privileges. APRN licensure requirements include holding an unencumbered South Dakota RN license or multistate

privilege to practice, a graduate degree in nursing, and national certification within role and population foci; certain exemptions are allowed.

■ Reimbursement

CNPs and CNMs receive Medicaid reimbursement at 90% of the physician 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 Schedules II, III, and IV CSs. CNPs and CNMs have two CS registration options. They may seek independent state registration and independent DEA registration in all schedules, or they may act as an agent of an institution, using the institution’s registration number to prescribe, provide, or administer CSs. CS authority is granted by separate application to the South Dakota Department of Health.

CNPs and CNMs may request and receive prepackaged drug samples, which the NP or nurse midwife are authorized to prescribe. A drug sample means a prepackaged unit of a prescription drug supplied by the manufacturer and provided at no charge to the patient. An NP or nurse midwife may provide prepackaged, labeled drug samples to the NP’s or nurse midwife’s patients for conditions being treated by the NP or nurse midwife. Each sample drug shall be accompanied by written administration instructions.

Prior to prescribing any CSs listed in SDCL Chapter 34-20B, an NP or nurse midwife who meets state and federal CS registration requirements shall register with the state’s PDMP and meet requirements in Chapter 34-20E, including standards for documentation of patient care. CRNAs and CNSs do not have prescriptive authority; however, CNSs may order and dispense durable medical equipment and therapeutic devices in collaboration with a physician.

Tennessee

www.tnaonline.org

www.tn.gov/health

www.campaignforaction.org/state/tennessee

■ Legal authority

The Tennessee BON grants APRNs authority to practice via a license and regulates their practice. APRNs are defined in regulation and include CNP (NP in regulation), CNS, CNM, and CRNA roles. APRNs meeting requirements for prescriptive authority are eligible for a certificate that is designated “with certificate to prescribe.”

APRNs must hold a current RN license in Tennessee or a compact state if their home state is a compact state. APRNs who prescribe must have protocols that are jointly developed by the APRN and a collaborating physician. Medical Board rules that govern the collaborating physician of the APRN prescriber are jointly adopted by the BOM and BON.

Physicians who collaborate with APRN prescribers are not required to be on-site but must personally review and sign 20% of the charts within 30 days; physicians are authorized to review charts electronically when the APRN is working in a free or reduced-fee clinic. 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. APRNs are required to hold a master’s degree or higher in a nursing specialty and national certification to enter practice in this state.

■ Reimbursement

Tennessee’s private insurance laws mandate reimbursement of APRNs. A managed-care antidiscrimination law prevents MCO discrimination against APRNs (specifically CNPs, CNSs, CNMs, and CRNAs) as a class of providers. However, not all organizations are credentialing and accepting APRNs into their network (as of now). This is a major issue being addressed by the Tennessee Nurses Association and private APRN practice owners.

BC/BS credentials APRNs in most of their programs and provides 100% reimbursement to primary care NPs in the TennCare program; BC/BS also reimburses CNMs and CRNAs. Other MCOs participating in the TennCare program also credential APRNs

and assign an established patient panel upon individual review of specialty.

■ Prescriptive authority

APRNs who have a BON-issued certificate to prescribe may prescribe legend and Schedules II, III, IV, and V CSs pursuant to protocols. Preauthorization is required for off-formulary medications and for Schedules II or III opioid prescriptions of more than a 30-day supply. Legislation passed in 2018 (Public Chapter No. 1039) amends prescriber requirements, now requiring the provider to confer with the CS database prior to issuing a prescription for CSs as a new course of treatment, prior to the issuance of each new prescription for the CS for the first (90) days of a new episode of treatment, and shall check the CS database for that patient at least every 6 months when that prescribed CS remains part of the treatment [TCA, Section 53-10-310 (e) (1)].

Additionally, the 2018 legislation places limits and requirements on the number of opioids prescribed and dispensed, limiting opioid prescriptions to up to a 3-day supply with a total of 180 morphine milligram equivalents (MME) for those 3 days. This limitation to supply count is subject to a number of exceptions under certain circumstances outlined in Tennessee Code Annotated, Title 63, Chapter 1, Part 1. Prescribing under these exceptions requires the prescriber to check the CS monitoring database, personally conduct a physical exam of the patient, consider nonopioid alternatives, obtain informed consent, including counseling about neonatal abstinence syndrome and contraception for women of childbearing age, and document the ICD-10 code for the patient’s primary disease as well as the term “medical necessity” on 30-day prescriptions. These 10-, 20-, and 30-day opioid prescriptions will only be filled by dispensers in an amount that is half of the full prescription at a time, requiring patients and pharmacists to consider whether the patient requires the full amount prescribed.

There are still further exceptions for patients, including those who are undergoing active or palliative cancer treatment; receiving hospice care; diagnosed with sickle cell disease; receiving opioid therapy in a hospital; currently treated by a pain management specialist or collaborating provider in pain management; patients who have received a 90-day or more opioid prescription supply in the year prior to April 2018 or subsequently do under one of the exceptions, which include medication-assisted treatment or suffering severe burns or major physical trauma.

Both the collaborating physician’s name and address must be printed on the

prescription blank; however, the APRN may sign the prescription. NPs may request, receive, and issue pharmaceutical samples.

Texas

www.bon.texas.gov

www.cnaptexas.org

www.texasnp.org

www.campaignforaction.org/state/texas

■ Legal authority

The BON is authorized by the NPA to regulate APRNs. APRNs are licensed in one or more of the following recognized roles: NP, CNS, CNM, or CRNA. The APRN’s SOP is based on advanced practice education, experience, and the accepted SOP of the associated population focus area. The APRN acts independently and/or in collaboration with the healthcare team.

The authority to make a medical diagnosis and write prescriptions must be delegated by an MD or DO using written delegation protocols or other written authorization in addition to a prescriptive authority agreement detailing those drugs and devices, which may be ordered or prescribed by the APRN. These two documents may be combined into a comprehensive document providing authority for both diagnosing and prescribing or ordering.

The rules define protocols as written authorization to provide medical aspects of care. Protocols should allow the APRN to exercise professional judgment and are not required to outline specific steps the APRN must take, but they are required to contain certain elements regarding prescriptive authority. Hospitals may extend privileges to APRNs but are not required to do so. Hospitals electing to extend clinical privileges to APRNs must use a standard application form and afford due process rights in granting, modifying, or revoking those privileges.

■ Reimbursement

All APRN categories are eligible for direct Medicaid reimbursement at 92% of physician payment. Under certain circumstances, physicians in the Texas Medicaid Program may bill for an APRN’s services and receive 100%. Some programs, such as Texas Health Steps, reimburse all providers at the same rate. APRNs may be PCPs in Medicaid and CHIP managed-care networks regardless of whether their collaborating physician is in network. APRNs are listed in the Texas Insurance Code as practitioners who must be reimbursed by indemnity health insurance plans.

■ Prescriptive authority

APRNs may be delegated prescriptive authority by a physician. This includes nonprescription, legend, and Schedules II, III, IV, and V CSs under certain circumstances contained within 22 Texas Administrative Code §222. Schedules III, IV, and V CSs authority may be delegated with the following limitations: APRNs may only prescribe a maximum 90-day supply; the APRN must consult with the physician before authorizing a refill; and APRNs may not prescribe CSs to a child under age 2 years without physician consultation, which must be noted in the chart. Effective September 2017, APRNs must check the Prescription Monitoring Program prior to writing a prescription for a CS (H&S Code §481.0764).

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

Utah

www.dopl.utah.gov/index.html
<http://utahnp.enpnetwork.com>
www.campaignforaction.org/state/utah

■ Legal authority

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

The APRN SOP is defined by set standards from national, professional, and 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 hold a master's degree or higher and be nationally certified to obtain licensure. Utah legislature was the first to adopt the APRN compact in 2004.

■ Reimbursement

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

■ Prescriptive authority

APRNs, including CNMs, have prescriptive authority for all legend drugs and devices, now including Schedules III, IV, and V CSs, within their SOP. A consultation and referral plan are required if prescribing Schedules II or III CSs in a pain clinic and if prescribing Schedule II CSs in all other settings with some exceptions.

APRNs can prescribe Schedule II CSs without a consultation and referral plan in settings other than a pain clinic if they meet experience requirements (have the lesser of 2 years of licensure as an APRN or 2,000 hours of experience as an APRN), the CS Database is consulted and follows prescribing for chronic pain guidelines.

APRNs are statutorily prohibited from establishing an independent pain clinic without a consultation and referral plan. APRN-CRNAs do not require a consultation or referral plan for their practice. CRNAs may order and administer drugs, including Schedules II, III, IV, and V CSs, in a hospital or ambulatory care setting; they may not provide prescriptions to be filled outside the hospital. APRNs, including CNMs and CRNAs, receive a DEA number after passing a CS exam and obtaining a state CS license; CRNAs may use facility DEA numbers under certain conditions. APRNs and CNMs may sign for and dispense drug samples.

Vermont

<https://www.sec.state.vt.us/professional-regulation.aspx> www.vtnpa.org
www.campaignforaction.org/state/vermont

■ Legal authority

The Vermont BON grants APRNs the authority to practice and regulates their practice. APRNs include CNP (NP in regulation), CNS in psychiatric and mental

health nursing, CNM, and CRNA roles. APRNs are independent providers after a transition to practice requirement is met (2,400 hours and 2 years) with an SOP defined in statute and regulations. The requirement for board-approved practice guidelines following the transition to practice requirement was removed in the 2018 legislative session; however, regulatory amendments have not been completed at the time of publication. According to agency protocols, APRNs are authorized to admit patients to a hospital and hold hospital privileges. APRNs are required to have a graduate degree in nursing and hold national board certification to enter practice.

■ Reimbursement

BC/BS reimburses psychiatric NPs using a provider number. Although legislation requiring or prohibiting third-party reimbursement does not exist, insurance companies may reimburse NPs depending on policies. Legislation passed in 2017 authorizes reimbursement to APRNs providing telehealth services within and outside of a healthcare facility.

■ Prescriptive authority

APRNs have full prescriptive authority, including Schedules II, III, IV, and V CSs, within the SOP. APRNs have the same privileges dispensing and administering drugs as physicians. Prescribers are required to query the Vermont Prescription Monitoring System when prescribing a new or renewal prescription for an opioid within Schedules II, III, and IV CSs and when starting a patient on nonopioid Schedules II, III, or IV CSs for nonpalliative long-term pain therapy for more than 90 days. NPs register for their own DEA numbers and are authorized to request, receive, and/or dispense pharmaceutical samples. Prescriptions are labeled with the APRN's name.

Virginia

www.dhp.virginia.gov
www.vcnf.net
www.campaignforaction.org/state/virginia

■ Legal authority

The Virginia BON and BOM have joint statutory authority to regulate licensed NPs (LNPs). LNPs include NP, CNM, and CRNA roles. CNSs are recognized as APRNs; however, CNSs are registered solely with the BON and do not have prescriptive authority. NPs practice in collaboration and consultation within a written or electronic practice agreement with a patient-care team physician as part of a patient-care team; however, legislation passed in 2018 authorizes an NP

with the equivalent of 5 years of full-time clinical experience to practice without a written or electronic practice agreement following submission of an attestation of experience from a patient-care team physician to the boards.

NPs practicing without a written or electronic practice agreement must (1) practice within the scope of their clinical and professional training and limits of their knowledge and experience and consistent with applicable standards of care, (2) consult and collaborate with other healthcare providers based on clinical conditions of the patient, and (3) establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate healthcare providers. LNPs identified CNMs practice in consultation with a licensed physician in accordance with a practice agreement, and LNPs identified as CRNAs practice under the supervision of a physician.

NP practice is based on education, certification, and a written practice agreement, and NPs are included in the list of professions authorized to perform surgery. According to the Virginia BON, NPs are not statutorily prevented from being PCPs, and no law or regulation prevents them from admitting patients to the hospital and holding hospital privileges. Virginia state law does not include NPs in its “any willing provider” language. A master’s degree in nursing and national board certification are required to enter practice in Virginia. NPs are also authorized to certify medical necessity of durable medical equipment for Medicaid reimbursement.

■ Reimbursement

Board-certified NPs and CNMs are reimbursed by Medicaid at 100% of the physician rate. PMH NPs are paid the same rate for psychiatric diagnosis, evaluation, and psychotherapy services as a PCNS, which is 67% of the rate currently paid to Medicaid-enrolled psychiatrists. For other procedures, such as physical exams, PMH NPs are reimbursed at the same rate as other NPs.

NPs can independently bill for services with insurers; however, payment is dependent upon individual company policy. Virginia has an “any willing provider” law, but it applies only to mandated providers and, among APNs, only PCNSs and CNMs are mandated providers. CNMs and CNSs in psychiatric health receive third-party reimbursement.

■ Prescriptive authority

Authorized LNPs may prescribe all legend drugs, including Schedules II, III, IV, and V CSs, as defined in the LNP’s practice agreement. A practice agreement,

developed between the NP and the patient-care team physician and maintained by the NP (which is to be provided to the Joint Boards of Nursing and Medicine upon request), lists the drug categories the NP will prescribe. NPs may only prescribe legend drugs if “such prescription is authorized by the practice agreement between the NP and physician.” The prescription must include the NP’s name and prescriptive authority number. NPs authorized to practice without a practice agreement may prescribe all legend drugs, including Schedules II, III, IV, and V CSs.

CNMs may prescribe Schedules II, III, IV, and V CSs. Physicians who enter into a practice agreement with an LNP may only collaborate at any one time with up to six NPs with prescriptive authority. Periodic electronic or chart review is required, and physician collaboration and consultation may be satisfied via telemedicine. The collaborating physician is not required to regularly practice at the same site as the NP with prescriptive authority. A separate practice site may be established.

The joint regulations of the BON and BOM include requirements for continued NP competency, including 8 hours of CE in pharmacology or pharmacotherapeutics for each biennium. LNPs may receive and dispense drug samples under an exemption to the state Drug Control Act, which states that the act “shall not interfere with any LNP with prescriptive authority receiving and dispensing to his own patients manufacturer’s samples of CSs and devices that he is authorized to prescribe according to his practice setting and a written agreement with a physician.”

Washington

www.doh.wa.gov/LicensesPermitsandCertificates/NursingCommission.aspx

www.auws.org

www.wsna.org

www.campaignforaction.org/state/washington

■ Legal authority

The Nursing Care Quality Assurance Commission grants APRNs the authority to practice and regulates their practice; APRNs are designated as ARNPs in statute and regulation, which include NP, CNS, CNM, and CRNA roles. ARNP practice is independent, and ARNPs assume primary responsibility for continuous and comprehensive management of a broad range of patient care, concerns, and problems. ARNP SOP 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 are required to obtain licensure as an ARNP in Washington.

■ Reimbursement

Medicaid reimbursement is available to ARNPs at 100% of the physician rate. Labor and industries reimbursement was increased in 2016 by rule from 90% to 100% of the physician rate. The Healthcare Service Contracts Act (RCW 48.44.290) makes it illegal to deny a healthcare service performed by an RN or ARNP within the person’s SOP if the healthcare contract would have approved the same service performed by a physician. The court ruled that the law did not have legal force in addressing reimbursement parity for ARNPs because it only applied to the agreement between the health plan and the patient. Consequently, many private insurance companies reimburse ARNPs at a lower rate than a physician for the same service.

■ Prescriptive authority

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

West Virginia

www.wvrnboard.com

www.campaignforaction.org/state/west-virginia

■ Legal authority

The West Virginia BON grants authority to practice and regulates the practice of APRNs; law defines advanced practice for RNs. APRNs include CNP, CNS, CNM, and CRNA roles. ARNP SOP includes the autonomous ability to assess, conceptualize, diagnose, analyze, plan, implement, and evaluate complex problems related to health autonomously. CRNAs administer anesthesia in the presence and under the supervision of a physician or doctor of dental surgery. Hospital credentialing for APRNs is dependent upon individual hospital policy.

APRNs must have graduated from an accredited graduate program and be nationally board certified to enter practice in West Virginia.

■ Reimbursement

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

■ Prescriptive authority

Qualified APRNs have prescriptive authority requiring a collaborative relationship with a licensed physician. Legislation passed in 2016 authorizes limited autonomous prescriptive authority, excluding Schedules I and II CSs, antineoplastics, radiopharmaceuticals, and general anesthetics, following 3 years of a duly documented collaborative relationship with a physician.

The law provides for the development of the Joint Advisory Council on Limited Prescriptive Authority, comprised of MDs, DOs, APRNs, a pharmacist, a consumer, and a representative from a school of public health or an institution of higher education who may advise the BON regarding collaborative agreements and evaluate applications for APRNs to prescribe without a collaborative agreement.

Prescriptive authority includes Schedules III, IV, and V CSs, with some restrictions. Drugs listed as Schedule III CSs are limited to a 30-day supply, and rules apply when prescribing for the treatment of a chronic condition (§30-7-15a (b)). Rules and regulations specify that APRNs must meet specified pharmacology education requirements. When required, the written collaborative agreement must include guidelines or protocols describing the individual and shared responsibility between the APRN and physician with periodic joint evaluation of the practice and review/

updating of the written guidelines or protocols.

No supervision requirement exists; APRNs are not required to be employed by a collaborating physician. The APRN works from an exclusionary formulary and Schedules I and II CSs, antineoplastics, radiopharmaceuticals, and general anesthetics are prohibited. Prior to the initial provision of a pain-relieving CS, the APRN must access the West Virginia Controlled Substances Monitoring Program repository and database to determine if the patient has obtained any CS from another prescriber within the 12-month period preceding the current visit. This must be documented and must be accessed by the current prescriber at least annually when treating a chronic pain condition. A DEA number is issued directly to APRNs by the DEA, and APRNs are authorized to sign for and provide drug samples.

Wisconsin

www.wisconsinnurses.org
www.dsp.wi.gov/Licenses-Permits/Credentialing/Health-Professions
www.campaignforaction.org/state/wisconsin

■ Legal authority

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

■ Reimbursement

Specified, reimbursable billing codes have Medicaid reimbursement of 100% as submitted by all master's degree-prepared NPs or NPs who are certified. Reimbursement is up to the maximum allowed for physicians billing for the same service. Qualified NPs are paid directly regardless of their employment site or arrangement. There are Medicaid bonuses for NPs working in certain areas or for certain pediatric visits. CHAMPUS reimburses NPs, and home health

RNs bill under their own provider number. Third-party reimbursement has not been addressed legislatively. Some managed-care panels are open to NPs, but few allow NPs to be the PCP of record.

■ Prescriptive authority

Eligible APNPs may prescribe legend drugs and Schedules II, III, IV, and V CSs as a delegated medical act under the NPA. Wisconsin Administrative Rule §N 8.06 describes limitations on prescriptive authority for Schedule II CSs. APNPs may dispense complimentary pharmaceutical samples; they may also dispense drugs to a patient if the treatment facility is located at least 30 miles from the nearest pharmacy.

Wyoming

<https://nursing-online.state.wy.us>
www.wyonurse.org
www.campaignforaction.org/state/wyoming

■ Legal authority

The Wyoming BON grants APRNs the authority to practice via licensure and regulates their practice. APRNs include CNP, CNS, CNM, and CRNA roles. APRNs are not required to have a collaborative or supervisory relationship with a physician. The SOP of an APRN is defined in statute, within the NPA, and includes prescriptive authority and management of patients commensurate with national organizations and accrediting agencies.

APRNs are statutorily defined as PCPs and may be permitted to admit patients to a hospital and hold hospital privileges, depending on individual hospital policies. A doctorate or master's degree in nursing in a specific APRN role and national board certification in that role are required to enter practice as an APRN in Wyoming.

■ Reimbursement

APRNs are authorized to receive Medicaid payments at 85% of the physician rate. All PCPs may receive third-party payment; however, policies differ among third-party payers.

■ Prescriptive authority

BON-approved APRNs may independently prescribe legend and Schedule II, III, IV, and V CSs. APRNs are considered independent providers and register for their own DEA numbers. APRNs who have prescriptive authority are legally authorized to request, receive, and dispense pharmaceutical samples. This is not addressed by the BON but possibly the Pharmacy Board, and prescriptions are labeled with the APRN name. ^{NP}