

24th Annual Legislative Update

AN NP EXCLUSIVE



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APRN consensus model implementation and planning

Abstract: *The Annual Legislative Update describes the legislative issues that have the most impact on nurse practitioners and other advanced practice nurses across the country.*

By **Susanne J. Phillips, MSN, FNP-BC**

This year, a record number of states reported activity in planning and implementation of the Advanced Practice Registered Nurse (APRN) Consensus Model Regulations. A total of 17 states passed legislation, adopted regulations, or are planning for these activities in coordination with boards of nursing and professional associations. The practice act language addressing licensure, accreditation, certification, and education of advanced practice nurses is well on its way to becoming standardized, which will allow APRNs to address provider shortages across the nation.

States who are in the preparation and planning stages for implementation of statutory and regulatory amendments to one or more of the components of the Consensus Model include Arkansas, Delaware, Idaho, Massachusetts, Minnesota, Missouri, Montana, New Hampshire, Virginia, Washington, West Virginia, and Wisconsin. These states report possible submission during the 2012 or 2013 sessions.

States that have completed or are in the process of statutory or regulatory changes consistent with the APRN Consensus Model include Georgia, Kansas, Kentucky, Nevada, Oklahoma, Tennessee, and Washington. The State of Georgia reported the passage of legislation including clinical nurse specialists (CNSs) as APRNs. The broadest changes occurred in Kansas, where the State adopted title, licensure qualifications, minimum educational degree standards, and continuing education standards for APRNs. Kentucky passed legislation pertaining to licensure of APRNs and accreditation of APRN educational institutions. Nevada passed legislation requiring national certification for licensure as an APRN effective July 2014, and Oklahoma is working on regulations reflecting the passage of legislation affecting titling of APRNs. In Washington, the Nursing Care Quality Assurance Commission (NCQAC) supported a petition from the CNS organization

to come under the ARNP title. The revision process for rule change may begin in early 2012.

Two states, Michigan and Tennessee reported submission of legislation pertaining to the APRN consensus model; however, at the time of print, the legislation was pending. Legislation to establish a license for nurse midwives, nurse practitioners (NPs), and CNSs was submitted to the Michigan Legislature, and language to include the “APRN” title for NPs and advanced practice nurses was submitted in Tennessee.

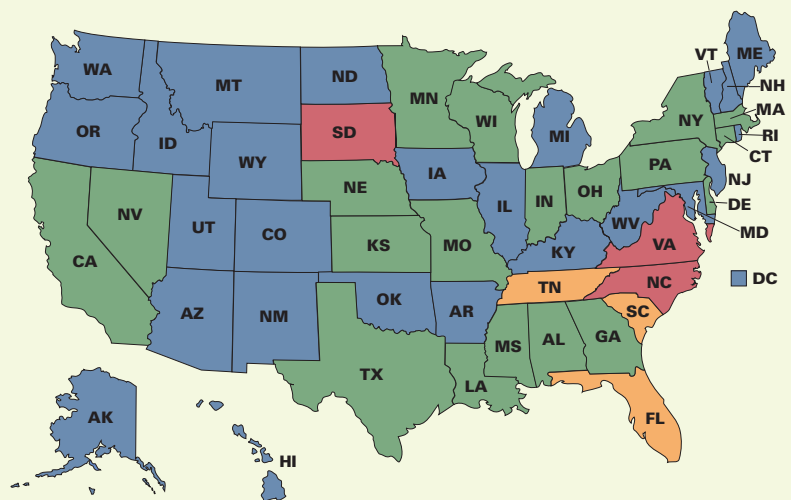
■ Legislative and scope of practice changes for APRNs

Several states passed legislation improving APRN’s delivery of care. In Arkansas, HB 1172 (Hall) was passed authorizing advanced practice nurses to enter into a collaborative agreement with area health education centers, thereby improving access to qualified healthcare professionals in those settings. Georgia reported the passage of legislation authorizing APRNs to sign, certify, and endorse all documents relating to healthcare; however, this language excludes the authority to sign death certificates or assign a percentage of a disability rating. Hawaii amended statutes to require hospitals to recognize APRNs with prescriptive authority to act as primary care providers in those institutions.

In Iowa, the legislature passed two laws pertaining to ARNPs. The first is an act allowing the Department of Transportation to accept reports from ARNP and PAs disclosing a physical or mental condition that renders a person incompetent to operate a motor vehicle, and the second law authorizes ARNPs to sign death certificates. New Hampshire reported new authorization for APRNs to sign Fish & Game permits for crossbow. In New Jersey, legislation was passed including APNs in the definition of a “physician” providing for the use of Physician Orders for Life-Sustaining Treatment and requires them to pursue

Keywords: advanced practice registered nurses, healthcare administration, legislation, regulations

Summary of APRN legislation: Legal authority to practice*



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

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

* This table provides a state-by-state summary of the degree of independence for all aspects of NP scope of practice, including diagnosing and treating (except prescribing). See Summary of APN legislation: Prescriptive authority for a state-by-state analysis of NP prescriptive authority.
 ** This information may apply to other APNs (clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists).
 † State with APRN Board.
 ♦ NPs may practice independently without physician involvement after 24 months of practice.
 ++ No physician collaboration required for APNs working in a hospital or ASTC

education in “end-of-life care.” At the time of press, this legislation was pending the Governor’s signature. Additionally, the New Jersey legislature passed legislation including APNs among the recognized providers in a pilot Accountable Care Organization in Medicaid Act. Legislation authorizing APNs to declare cause of death and sign death certificates is pending at the time of print.

New York reported new statutory authorization for NPs to execute death certificates and to conduct medical exams and reports required for admission to assisted living or adult care facilities. In North Carolina, NPs and PAs now have authority to complete cause-of-death certifications for registration. Pennsylvania has a similar bill pending in the

legislature at the time of print. Texas reported the passage of legislation removing the population restriction that prevented APRNs from signing for disability placards in counties with less than 125,000 people.

The Mississippi Nurses Association proposed legislation removing all requirements for physician involvement in scope of practice. Although the bill did not get out of committee during the legislative session, an agreement for regulatory change with the Board of Medical Licensure and the Mississippi State Medical Association was negotiated. This change authorizes a NP who cannot secure a collaborating physician to have a 90-day grace period with an additional 90-day grace period if necessary. The Mississippi Nurses Association is pleased with this outcome and with an opportunity to demonstrate autonomous practice.

■ Changes in regulatory authority

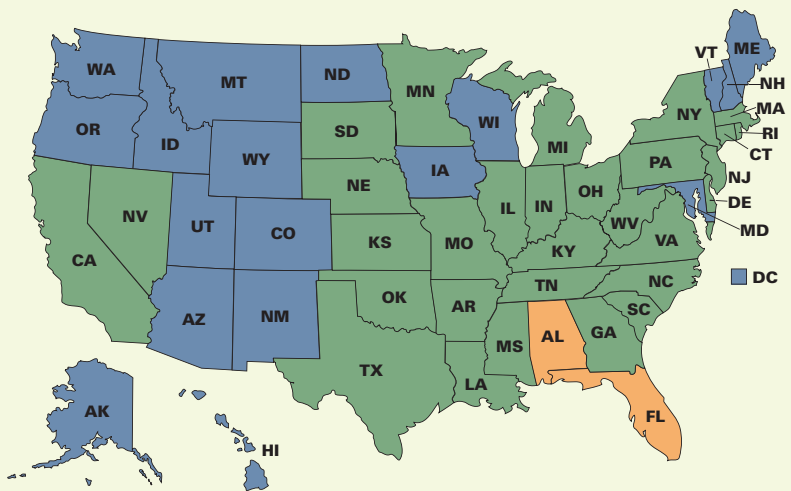
Additional regulatory changes to the state’s nurse practice acts included CEU requirement changes to include pharmacology and clinical management hours for APRNs in Arkansas, the amendment of degree terminology for certification as a NP, CNS, or CRNA to include all graduate degrees in nursing or related field in Connecticut, and the removal of Interim Approval as an option for APRNs who have not yet passed national certification exams. New Jersey reported several regulatory changes relating to practice. These included the inclusion of APNs as PCPs in Hospice Licensing Standards and Childhood Lead Screening, changes to titling of CRNAs in hospitals to be consistent with APN statutes and BON regulations, and the removal of supervisory language of APN/anesthesia nurses by anesthesiologists. Additional regulations that have been amended to include APNs in New Jersey include the recognition of APNs as PCPs who may provide diagnosis supporting the need for prosthetic and orthotic devices, recognition of APNs as providers under Medical Services for the Juvenile Justice Commission, and the inclusion of psychiatric APNs as those providers authorized to recommend placement in Behavior Accountability Units.

Total number of APNs reported by BONs in 2011

State	Total	NPs	CNSs	CNMs	CRNAs
Alabama	3,496	1,873	92	20	1,511
Alaska	874	718	^	^	156
Arizona	4,560	3,627	181	207	545
Arkansas	2,041	1,232	130	25	659
California	21,946	16,914	3,166	1,236	2,089
Colorado	4,755	3,037	719	330	669
Connecticut	3,665	3,354*	*	215!	*
Delaware	1,178	696	122	33	327
District of Columbia	1,348	1,034	44	101	169
Florida	13,594	13,519	75	*	*
Georgia	7,348	4,837	293@	436	1,782
Hawaii	966	*	*	*	*
Idaho	1,080	635	42	33	371
Illinois	7,056	4,366	999	389	1,653
Indiana	2,841	*	*	*	!
Iowa	1,891	1,327	92	80	392
Kansas	3,721	2,142	610	72	897
Kentucky	4,248	2,817	170	99	1,162
Louisiana	3,098	1,769	177	23	1,129
Maine	1,659	1,055	123	79	402
Maryland	4,378	3,172	@ (329)	211	666
Massachusetts	9,013	6,482	@ (938)	467	1,126
Michigan	6,814	4,056	!	318	2,440
Minnesota	5,246	2,945	524	246	1,531
Mississippi	2,485	1,861	!	31	593
Missouri	6,032	6,032	(392)^	(98)^	(1,618)^
Montana	738	502	42	47	148
Nebraska	1,593	979	94	31	489
Nevada	836	696	*	*	141!
New Hampshire	1,325	*	@	*	*
New Jersey	4,600	*	*	! (BOME)	*
New Mexico	1,880	1,162	163	175!	380
New York	16,031	16,031	!	!	!
North Carolina	7,149	3,904	82	237	3,904
North Dakota	821	456	45	11	302
Ohio	9,897	5,325	1,691	337	2,544
Oklahoma	2,010	1,092	249	58	611
Oregon	3,089	2,421	168	#	470
Pennsylvania	6,944	6,944	***	***	***
Rhode Island	1,036	607	119@	69	241
South Carolina	3,275	1,797	43	105	1,352
South Dakota	943	440	80	27	396
Tennessee	7,213	4,843	108	108	2,154
Texas	13,952	8,588	1,459	369	3,536
Utah	1,551	1,195 (APRNs)		136	220
Vermont	1,134	539	60	62	323
Virginia	6,535	6,092	443	204^	1372^
Washington	4,957	3,811**	N/A	359	787
West Virginia	1,423	875	73	61	414
Wisconsin	3,802	*	*	*	*
Wyoming	463	278	20	17	138

* Combined with total number of APNs/APRNs for that state
 ** Number includes PMH CNSs with NPs
 *** PA only recognizes CRNPs
 ! Not recognized as an APN/APRN
 ^ Included in total number of NPs
 @ Psychiatric clinical nurse specialists recognized as APNs/APRNs only
 # Licensed/certified as NPs

Summary of APRN legislation: Prescriptive authority*



- NPs** are authorized to prescribe legend and controlled substances independent of physician collaboration, delegation, or supervision: AK, AZ, CO, DC, HI, IA, ID, MD, ME, MT, ND, NH, NM, OR, UT†, VT, WA, WI, WY
- NPs** are authorized to prescribe legend and controlled substances with some degree of physician collaboration or delegation of prescriptive authority in statute or regulation: AR, CA, CT, DE, GA, IL, IN, KS, KY, LA, MA, MI, MN, MO, MS, NC, NE, NJ, NV, NY, OH, OK, PA, RI, SC, SD, TN, TX, VA, WV
- NPs** are authorized to prescribe legend drugs only with some degree of physician collaboration or delegation of prescriptive authority in statute or regulation: AL, FL

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

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

* This table provides a state-by-state analysis of NP prescriptive authority. For analysis of other aspects of the NP scope of practice (including diagnosing and treating), see *Summary of APRN legislation: Legal authority for scope of practice*.

** The information may apply to other APNs (clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists).

† Schedule IV and/or V controlled substances only

■ Activity to improve reimbursement for APRNs

Although there were no reported changes to rules and regulations pertaining to the reimbursement of APRNs throughout the nation, several states reported positive work in this area. Arizona, Colorado, Florida, and Texas reported ongoing planning and work with stakeholders for inclusion and reimbursement of APRNs. The Florida Action Coalition under the RWJF program for implementation of the IOM recommendations has identified recognition and reimbursement as a focus area. New York reported success in lobbying for inclusion of NPs in the New York State Health Insurance Plan Empire Plan offered by the two largest State Employee Unions. This program covers approximately 122,000 New York State employees and their families.

■ Improvements in prescriptive authority

Seven states reported improvement in the ability for APRNs to provide care to patients through improvements to prescriptive authority. Of note, North Dakota has removed the requirement for physician collaboration. Georgia reported new statutes that authorizes CNMs, CRNAs, CNPs, and CNS Psych/Mental Health providers to request, receive and sign for pharmaceutical samples; Hawaii eliminated the term “working relationship with a physician” from their controlled substances prescriptive authority statute and included authority to request and receive pharmaceutical samples for OTC and noncontrolled drugs. Illinois eliminated restrictions on the number of CS II medications the APRN was authorized to prescribe, thereby removing barriers to effective management of pain. Kentucky amended regulations authorizing the APRN to prescribe certain controlled substances for a longer period of time and Massachusetts secured prescriptive authority for CRNAs.

In Missouri, regulations are pending implementation for CS prescriptive authority; the Bureau of Narcotics and Dangerous Drugs are in the process of implementing the CS registration process for APRN prescriptive authority. Effective April 1, 2011, regulatory restrictions on refills for CS III medications prescribed by NPs has been removed in North Carolina.

For the first time, states are reporting legislation related to pain management clinics and specialists. Tennessee reported the passage of legislation that establishes regulations for pain management clinics and authorizes the Board of Medical Examiners, the Board of Nursing, and the Committee on Physician Assistants to promulgate implementation rules. Washington reported the passage of legislation limiting opioids and opioid medications in certain settings without consultation or qualification as a “pain management specialist.” It appears that states will be more aggressive in addressing the issue of regulatory authority in the pain management specialty. **NP**

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Alabama

<http://www.npalliancealabama.org/>

■ Legal authority

The Board of Nursing (BON) has sole authority to establish the qualifications and certification requirements of Advanced Practice Nurses (APNs) through R&Rs. APNs are defined as CRNPs, Certified Nurse Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), and Clinical Nurse Specialists (CNSs). The BON and Bureau of Medical Examiners (BOME) regulate the collaborative practice of physicians, CRNPs, and CNMs, and require them to practice with BON- and BOME-approved protocols. The collaborating physician and NP or CNM practicing with the physician must sign the protocol. The term "collaboration" does not require direct, on-site supervision of the activities of a CRNP or CNM by the collaborating physician. The term does require such professional oversight and direction as may be required by the R&R of the BOME and BON. The CRNP or CNM and collaborating physician shall be present in any approved practice site a minimum of 10% per month (if the CRNP or CNM is scheduled 30 or more hours per week) and a minimum of 10% on a quarterly basis (if scheduled less than 30 hours per week). "Remote practice site" is defined in rule, and the collaborating physician must visit each remote site at least quarterly. CRNP scope of practice (SOP) is defined in statute and regulation; APNs practice in accordance with national standards and functions identified by the appropriate specialty-certifying agency and in congruence with Alabama law. CNSs and CRNAs are not regulated by the joint committee (BON and BOME), and are not eligible for prescriptive authority. Alabama does not recognize APNs as primary care

providers (PCPs) and does not have "any willing provider" language in statute. CRNPs are required to have an MSN and national certification upon entry into practice, with a few exceptions: initial CRNP applicants are exempt from requirement for MSN on discretion of the BON if graduation was before 1996 in a post-BSN NP program, or graduation before 1984 from a non-BSN program preparing NPs. CRNAs must have a minimum of a master's degree from an accredited nurse anesthesia graduate program and be currently certified as a CRNA; CRNAs who graduated before December 31, 2003, are exempt from the master's degree requirement. CNS approval requires MSN as a CNS and national certification.

■ Reimbursement

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

■ Prescriptive authority

CRNPs and CNMs may prescribe, administer, and provide therapeutic tests and drugs, excluding Schedules II-V controlled substances, within an approved formulary. A BON and BOME joint committee recommends R&R governing the collaborative relationship between physicians, CRNPs, CNMs, and the prescription of legend (noncontrolled) drugs. The BON and BOME shall approve the protocols and formulary of legend drugs that may be prescribed by authorized CRNPs and CNMs. Authorization is tied to the collabora-

tive agreement; if CRNPs or CNMs change physicians, they must reapply. Prescription pads must include the physician's name and address and the CRNP or CNM name, RN license number, and Rx number. The CRNP or CNM who is in collaborative practice and has Rx privileges may sign for and dispense approved formulary drugs. CNSs and CRNAs are not regulated by the joint committee (BON and BOME) and are not eligible for prescriptive authority.

Alaska

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

<http://www.alaskanp.org/>

■ Legal authority

ANPs are regulated by the Alaska BON. ANPs include NPs and CNMs, and are defined as an RN who, because of specialized education and experience, is certified to perform acts of medical diagnosis and prescription, as well as dispense medical, therapeutic, or corrective measures under regulations adopted by the BON. Regulations require that an ANP must have a plan for patient consultation and referral, but a physician relationship is not required. SOP for ANPs is not directly defined in statute or regulation; however, regulation refers to the national certifying body for definition of SOP in specialty areas. ANPs in Alaska are statutorily recognized as "PCPs." Nothing in the law precludes admitting privileges for ANPs; however, hospitals require a physician preceptor with the exception of the Federal Alaska Native Hospital. Entry into NP practice requires a graduate degree in nursing and national board certification. Continuing education (CE) requirements for ANPs are 30 continuing education units (12 of these must be Rx hours, specifically, advanced pharmacotherapeutics) and 12 hours of CE in clinical

Legislative update key

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

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

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

management of patients every 2 years. CRNAs practice under separate rules and regulations, and CNSs are not licensed or recognized separately from their RN license.

■ Reimbursement

All healthcare in Alaska is provided on a fee-for-service basis; managed care does not exist. FNPs, PNs, and CNMs are authorized by law to receive Medicaid reimbursement; NPs receive 80% of the physicians' payment. A nondiscriminatory clause in the insurance law allows for third-party reimbursement to NPs; Alaska legally requires insurance companies to credential, empanel, and/or recognize ANPs. Alaska does not have "any willing provider" language in current law.

■ Prescriptive authority

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

Arizona

<http://www.azbn.gov>

<http://arizonanp.com/>

■ Legal authority

The Arizona State Legislature grants APRNs authority and the BON alone regulates their practice. APRNs include NPs (inclusive of CNMs), CRNAs, and CNSs. According to the BON, an RNP will refer a patient to a physician or other healthcare provider if a situation or condition occurs with a patient that is beyond the RNP's knowledge and experience. No formal collaboration agreement is required. RNP SOP is defined in the Arizona Administrative Code R4-19-507. RNPs are not statutorily recognized as PCPs; they are legally authorized by the Nurse Practice Act (NPA) to hold admitting and hospital privileges through R&Rs. However, the Arizona Department of Health regulations require that patients admitted to an acute care facility must have an attending physician. Acute care facilities apply this citation as the basis to deny independent admitting and hospital privileges to NPs. RNPs must have a graduate degree in nursing and national board certification in their practice focus area to enter into practice. NPs who were credentialed in Arizona, prior to the date when the graduate degree and national

board certification requirements went into effect, retain their privilege to practice in Arizona without the graduate degree and/or national board certification.

■ Reimbursement

NPs and other ARNPs may receive third-party reimbursement, enabled by the Department of Insurance statutes. The Arizona Health Care Cost Containment System (AHCCCS) (the Arizona version of Medicaid) contracts with MCOs and other provider networks on a capitated basis. AHCCCS NP reimbursement is 90% of the established physician rate. AHCCCS regulations specifically identify NPs as eligible to be PCPs.

■ Prescriptive authority

NPs have full prescriptive and dispensing authority, including controlled substances Schedules II-V, on application and fulfillment of BON-established criteria. NPs' prescriptive and dispensing authority is linked to the NP's area of population focus and certification (for example women's health NPs cannot prescribe meds to males except in cases of partner therapy for sexually transmitted diseases). Prescribing without documenting an assessment is a violation of the NPA. A NP with prescriptive and dispensing authority who wishes to prescribe a controlled substance must apply to the DEA for a registration number and file this number with the BON and the Board of Pharmacy. Drugs, other than controlled substances, may be refilled up to 1 year. CRNAs may prescribe drugs to be administered by a licensed, certified, or registered healthcare provider preoperatively, postoperatively, or as part of a procedure; CRNAs are not authorized to dispense.

Arkansas

<http://www.arsbn.org>

<http://www.arna.org/>

■ Legal authority

The BON grants APNs authority to practice via second licensure, separate from RN licensure. APNs are licensed and defined as an ANP, CNM, CNS, or CRNA. APNs practice independently with the exception of NPs who are not nationally certified. NPs who are not nationally certified qualify for licensure as an RNP; however, they must practice under physician direction/protocol. The BON ceased issuing RNP licenses in 1996. Hospital privileges for APNs are determined on a hospital-to-hospital basis according to the credentialing committee of each hospital. In 2005, "Any Willing Provider" language was enacted. Graduate-level APN education and national board certification is required for initial APN licensure.

■ Reimbursement

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

■ Prescriptive authority

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

California

<http://www.rn.ca.gov/>

<http://www.canpweb.org>

■ Legal authority

The California BRN grants legal authority to practice, regulates, and issues separate certification to APRNs. APRNs are defined as NPs, CNMs, CRNAs, and CNSs. NPs function under "standardized procedures" or protocols when performing medical functions, which are collaboratively developed and approved by the NP, physician, and administration in the organized healthcare facility in which they work. The SOP of a NP is defined within their standardized procedures, not in statute or regulation. NPs and CNMs are statutorily recognized as "PCPs" in California's Medi-Cal system. APRNs are not legally authorized to admit patients to the hospital; however, individual hospitals may grant hospital privileges to APRNs.

NPs must have a master's degree to practice; however, California does not require national certification.

■ Reimbursement

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

■ Prescriptive authority

NPs and CNMs may furnish or "order" drugs or devices, including controlled substances II-V when the drugs or devices are furnished or ordered by a NP or CNM in accordance with a standardized procedure. The act of "furnishing" requires physician supervision of the NP and CNM; however, physical presence of the physician is not required. The act of "furnishing" is legally the same as the act of prescribing. Prescriptions are labeled with the NP's or CNM's name only. NPs and CNMs may request, receive, and dispense pharmaceutical samples, and may dispense drugs, including controlled substances. NPs and CNMs must have authorization by the BRN to furnish controlled substances and must register for a DEA number. To obtain a BRN-issued furnishing number, NPs and CNMs must complete a 45-hour qualifying pharmacology course and 520 hours of physician-supervised experience post certification.

Colorado

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

<http://www.nurses-co.org/>

■ Legal authority

The State BON (Board) grants advanced practice authority to those RNs who meet the criteria set forth in the Colorado NPA and the Board Rules and Regulations (Rules) for inclusion on the Advanced Practice Registry (APR); regulates the practice of APNs; and affords title protection for the titles and abbreviations APN, CNM, CRNA, CNS, and NP. APNs are deemed to be independent practitioners. National certification in the Role and Population Focus has been required of all APR

applicants since July 1, 2010. APNs listed on the registry prior to July 1, 2010 may retain their listing on the APR without certification so long as the APN does not allow their advanced practice authority to lapse or expire. APNs engaged in an independent practice must be covered by professional liability insurance. The scope of advanced practice nursing is based on the professional nurse's scope of practice (SOP) within the APN Role and Population Focus; which may include, but is not limited to, performing acts of advanced assessment, diagnosing, treating, prescribing, ordering, selecting, administering, and dispensing diagnostic and therapeutic measures. Prescribing medication is not within the APN SOP unless the APN has applied for and been granted Prescriptive Authority by the Board. The NPA and Board Rules do not address and therefore do not prohibit APNs from being designated as PCPs or being granted Hospital Privileges; however, APNs are not currently recognized as PCPs in statutes and regulations under the jurisdiction of state agencies regulating healthcare.

■ Reimbursement

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

■ Prescriptive authority

Those Colorado APNs granted Prescriptive Authority by the Board enjoy full prescriptive authority within their Board-recognized Role and Population Focus including Schedule II-V controlled substances when the APN with Prescriptive Authority holds a valid DEA registration. Additional requirements include national certification in the Role and Population Focus of the APN, professional liability insurance if required by Board Rules, and additional experiential and safe prescribing requirements including preceptorship, mentorship, and an articulated plan for full prescriptive authority. Following completion of the mentorship, a one-time physician signature is required to attest to the existence of an articulated plan. The attestation form is kept on a file at the BON. The APN is responsible for reviewing his or her articulated plan on a yearly basis. Articulated plans may be audited by the BON. As of July 1, 2010, Collaborative Agreements are no longer required. Board Rules authorized APNs with prescriptive authority to receive and distribute a therapeutic regimen of prepackaged and labeled drugs including free samples.

Connecticut

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

<http://www.ctaprn.org/>

■ Legal authority

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

■ Reimbursement

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

■ Prescriptive authority

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

the institution, clinic, or other setting. APRNs are legally authorized to request, receive, and dispense pharmaceutical samples.

Delaware

<http://dpr.delaware.gov/boards/nursing/index.shtml>

<http://denurses.org/>

■ Legal authority

The Delaware BON regulates APNs and grants APN authority to practice. APNs are defined as NPs, CNSs, CNMs, and CRNAs. If the APN's SOP does not include independent acts of diagnosis or prescribing, practice authority is governed solely by the BON. If the APN wishes to provide independent acts of diagnosis or prescribing, the APN must apply to the JPC (composed of APNs, MDs, a pharmacist, and one public member). The JPC is statutorily empowered, with Board of Medical Licensure and Discipline (BMLD) approval, to grant independent practice and/or prescriptive authority to nurses who qualify. APNs must practice in a collaborative relationship with physicians while performing these services. The collaborative agreement is a written document that outlines the process for consultation or referral complementary to the APN's independent practice area. The collaborative agreement is defined as "a true collegial agreement between two parties where mutual goal-setting, access, authority, and responsibility for actions belong to individual parties and there is a conviction to the belief that this collaborative agreement will continue to enhance patient outcomes, and a written document that outlines the process for consultation and referral between an APN and physician licensed in Delaware, dentist, podiatrist, or licensed health care delivery system." If the agreement is with a licensed healthcare delivery system, the document must clarify that the system will supply appropriate medical backup for the purposes of consultation and referral. APN applicants must have a master's degree or postbasic certificate in a clinical nursing specialty, be nationally certified, submit a copy of their collaborative agreement, and show evidence of BON-specified relevant courses including advanced health assessment, diagnosis, and management of disorders within the clinical specialty, advanced pathophysiology, and advanced pharmacology. If the APN has graduated from an approved program more than 2 years before application, the APN must document the equivalent of at least 30 CE hours in pharmacology and other areas.

■ Reimbursement

Delaware has statutory provisions requiring health insurers, health service corporations, and health maintenance organizations

(HMOs) to provide benefits for eligible services when rendered by an APN acting within his or her SOP. APNs may be listed on provider panels; some providers are recognizing APNs on managed-care provider panels. CNMs have legislative authority under the Board of Health for third-party reimbursement. FPNs and PPNs also receive Medicaid reimbursement at 100% of the physician payment.

■ Prescriptive authority

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

District of Columbia

<http://hpla.doh.dc.gov/hpla/cwp/view,a,1195,q,488526,hplanav,%7C30661%7C,.asp>

<http://www.npadc.org/>

■ Legal authority

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

■ Reimbursement

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

■ Prescriptive authority

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

Florida

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

<http://www.floridanurse.org/>

■ Legal authority

The BON certifies and regulates ARNPs who are defined as ARNPs, CNMs, and CRNAs. ARNP SOP is defined in statute and includes the performance of medical acts of diagnosis, treatment, and operation pursuant to protocols established between the ARNP and MD, DO, or dentist. Within the framework of established protocols, ARNPs may order diagnostic tests, physical therapy, and occupational therapy. The degree and method of supervision, determined by the ARNP and MD, DO, or dentist, is specifically identified in written protocols and shall be appropriate for prudent healthcare providers under similar circumstances. ARNPs must file protocols with the BON when renewing the license and when there are changes to the protocol, and the physicians working with the ARNP must send the statement required in the medical practice act to the BOM. BOM and BON rules define general supervision as the ability to communicate/contact by telephone; on-site presence of the supervising practitioner is not required. ARNPs are authorized to admit patients to the hospital and hold hospital privileges; however, this authority is dependent upon privileges granted by the institution and the supervising physician. ARNP applicants must have a master's degree to qualify for initial certification and are required to hold national board certification to enter practice.

■ Reimbursement

ARNPs receive Medicaid, Medicare, CHAMPUS, and third-party reimbursement; however, Medicaid reimburses ARNPs at 100% of the physician rate only if the on-site physician countersigns the chart within 24 hours. Medicaid reimburses ARNPs at 85% of the physician rate if the physician is not on-site and does not countersign. In 2008, Florida initiated a pilot program for Medicaid managed care. Providers must be on approved panels. Managed-care companies are

prohibited from discriminating against the reimbursement of ARNPs if based on licensure. Private insurers must reimburse CNM services if the policy includes pregnancy care.

■ Prescriptive authority

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

Georgia

<http://www.sos.state.ga.us/plb/rn/>

<http://www.georgianurses.org/>

■ Legal authority

APRNs are authorized to practice and regulated by the BON. APRNs are defined as NPs, CNMs, CRNAs, and CNSs (all CNSs as of January 1, 2012 meeting education and national certification criteria). APRN practice is collaborative in nature. An APRN is authorized to perform advanced nursing functions and certain medical acts that include, but are not limited to, ordering drugs, treatments, and diagnostic studies through a "nurse protocol." A "nurse protocol" is defined as a written document signed by the NP and physician in which the physician delegates authority to the nurse to perform certain medical acts and provides for immediate consultation with the delegating physician under OCGA 43-34-23 or 25. APRNs may hold hospital privileges in limited situations, according to the Georgia Nurses Association. A master's degree or higher in nursing or other related field and national board certification is required for all APRNs at entry into practice except for CRNAs educated prior to 1999.

■ Reimbursement

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

■ Prescriptive authority

APRNs practice under protocol as defined by OCGA 43-34-25. A process exists 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. BON regulations governing protocols used by RNs require that the RN document preparation and performance specific to each medical act. "Medication orders" may be called into a pharmacy. APRNs are authorized to request and receive pharmaceutical samples.

Hawaii

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

■ Legal authority

The BON grants recognition of and regulates APRNs in Hawaii. APRNs are defined in the NPA as a NP, CNS, CNM, or CRNA, and have independent SOP and prescriptive authority. Recent legislation passed requiring hospitals licensed in Hawaii to recognize APRNs and to act as a PCP in their institutions. The minimum requirements to enter practice in Hawaii are a master's in nursing and national certification in the APRN's clinical specialty.

■ Reimbursement

Current law provides direct reimbursement to all APRNs and now 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 psychiatric CNSs and additional specialties of NPs. Medicaid reimburses at 75% of the physician payment. Hawaii Health 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 prescription medications, including Schedules II-V controlled substances, independently. APRNs with prescriptive authority are legally authorized to request, receive, and dispense pharmaceutical samples. NP prescribers' prescriptions are labeled with the NP name.

Idaho

<http://www.idaho.gov/ibn>

■ Legal authority

The BON regulates and grants authority to practice for APPNs. APPNs are defined as NPs, CNMs, CNSs, and RNAs. APPN licensure requires RN licensure, completion of an approved APPN program, and national

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

■ Reimbursement

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

■ Prescriptive authority

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

Illinois

<http://www.idfpr.com/dpr/WHO/nurs.asp>

<http://www.isapn.org/>

■ Legal authority

The Illinois Department of Professional Regulation's BON grants authority and regulates the practice of APNs. APNs are

defined as CNPs, CNSs, CNMs, and CRNAs. APNs must have a written collaborative agreement with a physician, podiatrist, or dentist except APNs who are credentialed and privileged in a hospital or ASTC. Collaboration is defined in Section 65-35 (b) between an APN and a collaborating physician, podiatrist, or dentist. APNs must meet in person with their collaborating physician once a month. APNs may provide services within a hospital or ASTC if clinical privileges have been granted by the facility. All new applicants must have a graduate degree in their APN specialty or a graduate degree in nursing and a certificate from a graduate-level program in one of the APN specialty areas. Additionally, APNs must hold national certification to enter into practice.

■ Reimbursement

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

■ Prescriptive authority

Prescriptive authority is delegated by the physician as a part of the written collaborative agreement or clinical privileges. An APN may prescribe Schedules III-V without restrictions and may prescribe Schedule II medications when certain conditions are met (225 ILCS 65/65-35). Recent legislation has passed removing some of the barriers to CS II prescribing. The collaborative agreement may authorize dispensing of medications and acceptance of sample medications.

Indiana

<http://www.in.gov/pla/nursing.htm>
<http://www.indiananurses.org>

■ Legal authority

The Indiana State BON grants the authority to and regulates APNs. The NPA defines APNs as NPs, CNMs, or CNSs. The BON does not issue separate licenses to NPs or CNSs. CNMs must apply for "limited licensure" to practice. APNs without prescriptive authority may function independently in their advanced practice; however, a Written Collaborative Practice Agreement (WCPA) is necessary if the APN seeks prescriptive authority. APN SOP is defined in regulation. If the NP holds a baccalaureate degree, national certification is required to obtain prescriptive authority. NPs with a graduate degree do not need to

be nationally certified for prescriptive authority to be granted.

■ Reimbursement

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

■ Prescriptive authority

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

Iowa

<http://www.state.ia.us/nursing/>
<http://www.iowanurses.org/>

■ Legal authority

The Iowa BON grants ARNPs authority to practice and regulates their practice through administrative rules. ARNPs are defined as NPs, CRNAs, CNMs, and CNSs. ARNPs are authorized to practice independently within their recognized nursing specialties, and collaborative practice agreements are not

required by the BON. SOP is broadly defined. ARNPs are statutorily recognized as PCPs; however, state law does not contain "any willing provider" language. ARNPs may hold hospital clinical privileges. Registration as an ARNP requires current licensure as an RN and certification by a national certifying body. A master's degree in nursing is only required for CNSs.

■ Reimbursement

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

■ Prescriptive authority

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

Kansas

<http://www.ksbn.org>

■ Legal authority

The Kansas BON regulates the practice of APRNs. The BON grants APRNs the authority to practice and defines them in one of the four roles: NPs, nurse midwives, NAs (Nurse Anesthetist) CRNAs (Certified Nurse Anesthetist), and CNSs. APRNs function in collaborative relationships with physicians and other healthcare professionals in the delivery of primary healthcare services. ARNPs make independent decisions about the nursing needs of patients and interdependent decisions with physicians in carrying out health regimens for patients; however, the physical presence of a physician is not required when care is given by the APRN. Any APRN who interdependently develops and manages the medical plan of care for patients or clients is required to have a signed authorization for collaborative practice with a physician who is licensed in Kansas (60-11-010 (b)). Each authorization for collaborative practice shall include a cover page containing the names and telephone

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

■ Reimbursement

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

■ Prescriptive authority

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

Kentucky

<http://kbn.ky.gov>

<http://www.kcnpnm.org>

■ Legal authority

The Kentucky BON grants APRNs authority to practice and regulates their practice. APRNs are statutorily defined as NPs, CNSs, CNMs, and CRNAs. APRNs practice in collaboration with a physician in Kentucky for prescriptive

purposes only. ARNPs may practice autonomously within their relative SOPs; however, they must practice in accordance with the SOP of the national certifying organization as adopted by the BON in regulation. NP SOP is defined in Kentucky statute, KRS 314.011: "APRNs shall seek consultation or referral in situations outside their SOP." APRNs are recognized as "PCPs" in regulation, and are legally authorized to admit patients to a hospital and hold hospital privileges; however, hospital regulations permit medical staff to set conditions. A master's degree, doctorate, or postmaster's certificate as an APRN and national board certification is required to enter practice in Kentucky.

■ Reimbursement

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

■ Prescriptive authority

APRNs may prescribe Schedules II-V controlled substances and nonscheduled legend drugs pursuant to separate "Collaborative Agreement for Prescriptive Authority for Nonscheduled Drugs (CAPA-NS)," and "Collaborative Agreement for Prescriptive Authority for Controlled Substances (CAPA-CS)." The CAPA-CS and -NS define APRN's scope of prescribing authority and are signed by the APRN and the physician. APRNs may prescribe scheduled medications with the following limitations: CS II controlled substances for a 72-hour supply with additional authority for psychiatric/mental health clinicians; Schedule III controlled substances may be prescribed for a 30-day supply without refills; Schedules IV and V controlled substances may be prescribed with refills not to exceed a 6-month supply with the following limitations: diazepam, clonazepam, lorazepam, alprazolam, and carisoprodol may be prescribed for 30 days without refills. CRNAs do not need CAPAs to deliver anesthesia care. The APRN alone signs his or her name to the prescription pad when prescribing. ARNPs must complete 5 contact Rx hours annually as part of their CE requirement. APRNs are legally authorized to request and receive drug samples (noncon-

trolled legend medications only) and may dispense pharmaceutical samples. Dispensing is applicable to APRNs working in health departments: APRNs may dispense with a written agreement with a local pharmacist.

Louisiana

<http://www.lsbm.state.la.us>

<http://www.lanp.org/>

■ Legal authority

APRNs are licensed by the BON and are defined as NPs, CNMs, CRNAs or RNAs, and CNSs. APRNs perform certain acts of medical diagnosis in accordance with a "collaborative practice agreement," a formal written statement addressing the parameters of the collaborative practice that are mutually agreed upon by the APRN and physician(s) or dentist(s) including consultation or referral availability, clinical practice guidelines, and patient coverage. APRNs' SOP is limited to their BON-recognized category and area of specialization. The APRN SOP includes "certain acts of medical diagnosis or medical prescriptions of a therapeutic or corrective nature, prescribing assessment studies, legend and certain controlled drugs, therapeutic regimens, medical devices and appliances, receiving and distributing a therapeutic regimen of prepackaged drugs prepared and labeled by a pharmacist, and free samples supplied by a drug manufacturer." Louisiana State law includes "Any Willing Provider" language pursuant to the passage of SB 135/ Act 106, and APRNs are legally authorized to hold hospital privileges. APRNs must be licensed as an RN, possess a master's degree or higher, and be certified by a national certifying body recognized by the board or meet "commensurate requirements" if certification is not available.

■ Reimbursement

The passage of SB 135/Act #106 in 2006 provides that any qualified plan shall not exclude direct reimbursement of healthcare services provided by an APRN as stated above. Medicaid managed care is required to reimburse FNPs and PNPs at a rate equal to that of physicians performing the same service. Medicaid recognizes FNPs and PNPs as primary care case managers/providers and will give assignment of NPs as the PCP or "Medical Home" under certain circumstances. APRNs are reimbursed at 80% of the physician fees per Medicaid; all billing must be under the APRN license, essentially eliminating "incident to" billing.

■ Prescriptive authority

APRNs have prescriptive authority in Louisiana, including Schedules II-V controlled substances. The BON has sole authority to develop, adapt,

and revise R&R governing SOP, including Rx authority, the receipt and distribution of sample and prepackaged drugs, and prescribing of legend and controlled drugs. An APRN who is granted limited Rx authority may request approval to prescribe and distribute controlled substances as authorized by the APRN's collaborating physician if the patient population served by the collaborative practice has an identified need. Prescribing distributed controlled substances (Schedules II-V) must be consistent with the practice specialty of the collaborating physician and the APRN's licensed category and area of specialization. APRNs with authority to prescribe or distribute controlled substances may not prescribe controlled substances to treat chronic or intractable pain, or obesity; additionally they may not prescribe controlled substance for themselves or a family member.

Maine

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

■ Legal authority

The Maine BON authorizes and regulates APRN practice. APRNs licensed by the BON are defined as CNPs, CNMs, CNSs, and CRNAs. CNSs practice in an independent role; however, a CNP who qualifies as an APRN must practice for at least 24 months under the supervision of a licensed physician, NP, or must be employed by a clinic or hospital that has a medical director who is a licensed physician. The CNP must submit written evidence to the BON upon completion of the required clinical experience. Following this period, the CNP practices independently. CRNAs are responsible and accountable to a physician or dentist. The APRN SOP, as defined in regulation, includes standards of the national certifying body and "consultation with or referral to medical and other healthcare providers when required by client healthcare needs." Psychiatric and Mental Health CNPs and certified psychiatric CNSs may sign documents for emergency involuntary commitment through EDs. APRNs are statutorily defined as "PCPs," and may be credentialed as Allied Staff for hospital privileges. Admitting privileges are not granted in this authority. Workers' compensation forms recognize CNPs and allow issuance of license plates and cards for the physically disabled. Current law requires a master's degree in nursing and national certification to enter into practice.

■ Reimbursement

The 1999 Act to Increase Access to Primary Health Care Services (HP617) requires reimbursement under an indemnity or managed-care plan for patient visits to

a 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, managed-care organizations are not required to credential any physician or CNP if their "access standards" have been met. Reimbursement under indemnity plans is mandated for master's-prepared, certified psychiatric/mental health CNSs; no other third-party reimbursement for APRNs is required by law. Some insurance carriers, however, reimburse independent CNPs. Medicaid reimburses in full, on a fee-for-service basis, for services provided by certified family NPs, CPNPs, and CNMs.

■ Prescriptive authority

CNPs and CNMs may prescribe and dispense drugs or devices, including Schedule II-V controlled substances, in accordance with rules adopted by the BON; approved CNPs and CNMs receive their own DEA numbers. BON rules require CNPs and CNMs to have a pharmacology course and prescribe from FDA-approved drugs related to the nurse's specialty. CNPs and CNMs may prescribe Schedule II-V controlled substances and drugs off-label, according to the common and established standards of practice. CNPs and CNMs may receive and distribute drug samples included in the formulary for Rx writing.

Maryland

<http://www.mbon.org>
<http://www.npamonline.org/>

■ Legal authority

The Maryland BON regulates APN practice. APNs are defined as NPs, CRNAs, CRNMs, and APRNs/Psychiatric Mental Health Nurses. SOP for NPs is independent, is defined in statute and regulations, and is in accordance with the Standards of Practice of the American Academy of Nurse Practitioners or any other national certifying body recognized by the board. Scope and standards of independent practice for NPs is defined in statute and regulations. The minimum degree required to enter practice in the State of Maryland is a master's degree; national board certification is also required.

■ Reimbursement

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

physician payment. Legislation allows due process for APNs listed on managed-care panels; APNs are not to be arbitrarily denied. The law does not require, however, that an HMO include NPs on the HMO panel as PCPs. Several commercial insurers reimburse NPs directly, however, at a rate of 75% to 85% of the physician's fee schedule.

■ Prescriptive authority

NPs and CNMs have full prescriptive authority, including Schedule II-V controlled substances. The scope of prescriptive authority is defined in statute. CNMs have statutory authority to prescribe based on a formulary mutually developed by the BON, BOM, and BOP. NPs and CNMs are authorized to obtain both federal and state DEA numbers. NPs are legally authorized to dispense medications in public health settings and student health clinics. Prescription containers are labeled with the NP or CNM name.

Massachusetts

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

■ Legal authority

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

■ Reimbursement

FNPs, PNPs, and adult NPs are reimbursed at 100% of the physician payment rate for Medicaid unless the NP is employed by the hospital in a hospital-based practice.

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

■ Prescriptive authority

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

Michigan

<http://www.minurses.org/>

<http://www.micnp.org/>

■ Legal authority

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

certification program that enables the registered nurse to handle tasks of a more specialized nature that are delegated to him or her... Without the benefit of a defined scope of practice, we are left with the scope indicated for a registered nurse and what tasks can be delegated by another licensee which is typically a physician." Under some HMOs and systems, NPs are recognized as "PCPs." Michigan does not have "any willing provider" language in statute. Michigan statute does not specifically authorize nurse specialists to admit patients or hold hospital privileges; however, this is dependent on the institution; hospitals generally grant these privileges. Nurse specialists are required to have a master's degree in nursing and national board certification to enter into practice.

■ Reimbursement

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

■ Prescriptive authority

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

Minnesota

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

■ Legal authority

The Minnesota BON grants APRNs the authority to practice and regulate their practice. APRN is defined as an RN certified by a national nursing certification organization acceptable to the BON to practice as a CNP, CNS, CNM, or CRNA. "The APRN must practice within a healthcare system that provides for consultation, collaborative management, and referral as indicated by the health status of the patient." Collaborative management is defined as "a mutually agreed upon plan between an APRN and one or more physicians ... that designates the scope of collaboration necessary to manage the care of patients." (Minnesota Statutes section 148.1717, subd. 6, 2008.) The APRN and physician(s) must have experience in providing care to patients with the same or similar medical problems. SOP for CNPs is defined in statute and CNPs are legally recognized as PCPs. Minnesota state law does not contain "any willing provider" language. APRNs are legally authorized to admit patients to hospitals and hold hospital privileges as defined within their SOP. Minnesota does not identify a minimum educational degree requirement for entry into practice; however, the state does require national board certification to enter practice.

■ Reimbursement

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

APRNs have statutory authority to receive and dispense sample drugs within their authorized SOP.

Mississippi

<http://www.msbn.state.ms.us>

<http://www.msnurses.org>

■ Legal authority

The Mississippi BON grants APRNs the authority to practice and regulates their practice. APRNs are defined as NPs, CRNAs, and CNMs and CNSs. NPs, CRNAs, and CNMs practice in a collaborative relationship with physicians in Mississippi. The collaborating physicians' practice must be compatible with the NP's practice. NPs must practice according to a BON-approved protocol agreed on by the NP and physician. NP applicants must submit official evidence of graduation from a graduate program with a concentration in the applicant's APN specialty. Practicing in a site not approved by the BON, with a physician not approved by the BON, or according to a protocol not approved by the BON is in violation of the NPA R&Rs. SOP is defined and regulated by the BON. NPs 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. APNs are required to have a master's degree in nursing and be nationally certified to enter into practice.

■ Reimbursement

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

■ Prescriptive authority

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

substances (II-V) may be prescribed pursuant to additional BON rules and regulations: the NP must have a DEA number, completed a BON-approved educational program, and submittal of a "controlled substance prescriptive authority protocol" to the BON. CNMs and CRNAs may order controlled substances within a licensed healthcare facility using BON-approved protocol or practice guidelines.

Missouri

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

■ Legal authority

The Missouri BON grants APRNs the authority to practice and regulates their practice. APRNs are defined as NPs, CNSs, CNMs, and CRNAs. APRNs practice in collaboration with physicians in Missouri. Collaborative practice includes written agreements, written protocols, or written standing orders. R&Rs define the Collaborative Practice Rule (CP). Three focus areas in the CP rule include (1) geographic areas to be covered, (2) methods of treatment that may be covered by CP arrangements, and (3) requirements for review of services provided pursuant to a CP arrangement. A written CP arrangement with a physician is not needed when the APRN is performing nursing acts consistent with the APRN's skill, training, education, and competence. A CP arrangement may be indicated to perform physician-delegated medical acts within the mutual SOP of the physician and APRN, and consistent with the APRN's skill, training, education, and competence. CRNAs practice under the direction of the surgeon, anesthesiologist, dentist, or podiatrist. Individuals are recognized by their specific clinical nursing specialty area as a CNS, NP, NM, or CRNA, which delineates their title and SOP as APRNs in R&Rs. When practicing outside their recognized clinical nursing specialty, individuals must practice and title as RNs only. Missouri law does not recognize APRNs as PCPs and does not contain "any willing provider" language. Additionally, APRNs are not legally authorized to admit patients or hold hospital privileges. NPs are required to hold a graduate degree in nursing and national certification to enter into practice in Missouri.

■ Reimbursement

Current law states "Any health insurer, nonprofit health service plan, or HMO shall reimburse a claim for services provided by an APRN, if such services are within the SOP of such a nurse." Medicaid reimbursement is made to APRNs enrolled as Missouri Medicaid fee-for-service providers and Medicaid-enrolled APRNs associated with a federally qualified healthcare or rural

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

■ Prescriptive authority

Prescriptive authority for NPs, CNSs, and CNMs includes prescription drugs and devices and Schedules III-V controlled substances as delegated by a physician pursuant to a written CP arrangement. CRNAs may not prescribe controlled substances. Schedule III prescriptions will be limited to a 120-hour supply with no refills. Delivery of such APRN healthcare services shall be within the APRN's advanced clinical nursing specialty area and a mutual SOP with the physician, and be consistent with the individual's skill, training, education, and competence. APRNs may receive/dispense samples within their Rx authority. A state Bureau of Narcotics and Dangerous Drugs number and DEA number is required. Prescriptions written by a NP are labeled with both the collaborating physician's and NP's name.

Montana

<http://www.nurse.mt.gov>

■ Legal authority

The Montana BON grants APRNs authority to practice and regulates their practice. APRNs are defined as NPs, CNSs, CNMs, and CRNAs. APRNs practice independently after completion of specific curriculum requirements and a national certifying exam by a BON-recognized national certifying body. According to the Montana BON, all APRNs involved in direct patient care must have an approved quality assurance program in place. NP SOP is defined in Rule ARM 24.159.1470. State law does not contain "any willing provider" language. APNs are legally authorized to admit patients and hold hospital privileges; however, this varies according to the rules and bylaws of each hospital. APRNs must have a master's degree in nursing and hold national certification to enter into practice. All APRNs must achieve mandatory CE hours for renewal every 2 years.

■ Reimbursement

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

insurers' law, mandatory coverage for APRNs does not apply to HMOs. APRNs receive 85% of the physician payment from BC/BS. Medicare reimbursement consistent with 1990 federal guidelines is in effect. APRNs are included as providers for workers' compensation.

■ Prescriptive authority

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

Nebraska

<http://www.hhs.state.ne.us/crl/nursing/Nursingindex.htm>

■ Legal authority

The Nebraska APRN Board grants APRNs the authority to practice and regulates their practice. APRNs are defined as NPs, CRNAs, CNMs, and CNSs. NPs and physicians practice collaboratively and have joint responsibility for patient care, based on the SOP of each practitioner. The collaborative agreement is contained within the integrated practice agreement (IPA). An IPA specifies, "The collaborating physician shall be responsible for supervision through ready availability for consultation and direction of the activities of the NP." If, after diligent effort, an NP is unable to obtain an IPA with a physician, the APRN Board may waive the requirement for an IPA if the NP has demonstrated proper course work, holds a master's degree or higher in nursing, has completed 2,000 hours under the supervision of a physician, and will practice in a geographic area where there is a shortage of healthcare services. NP SOP is defined in statute and includes illness prevention, diagnosis, treatment, and management of common health problems and chronic conditions. "PCP" status and "any willing provider" language were not reported in the survey. NPs without minimum hours of specific coursework, masters or doctoral degree, and/or at least 2,000 hours of the physician-supervised practice must

also have jointly approved protocols. Nebraska requires national board certification to enter practice.

■ Reimbursement

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

■ Prescriptive authority

Nebraska NPs are authorized full prescriptive authority including Schedules II-V medications, as defined in their statute. NPs may request, receive, and dispense pharmaceutical samples if the samples are drugs within their prescribing authority. CRNAs prescribe within their specialty practice; authority is implied in the statute. Qualified CRNAs, NPs, and CNMs may register for a DEA number.

Nevada

<http://www.nursingboard.state.nv.us>
<http://www.nvnurses.org/>

■ Legal authority

The Nevada BON grants APNs the authority to practice and regulates their practice. To qualify for APN certification, applicant must have completed an education program to prepare an APN (NP, CNS, CNW, and nurse psychotherapist) and be nationally certified in an APN role and population focus. If the applicant completed an APN program after June 1, 2005, the applicant must hold a master's degree in nursing or related health field. APNs in Nevada practice in collaboration with a physician. The APN must keep written protocols at every job site, together with a collaborative agreement signed by a BOME-approved physician. APN SOP is defined in regulation and includes performance of "designated acts of medical diagnosis, prescribe therapeutic or corrective measures, and prescribe controlled substances, poisons, dangerous drugs and devices." APNs are not recognized as PCPs under state law; however, APNs are legally authorized to admit patients to the hospital and hold hospital privileges.

■ Reimbursement

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

■ Prescriptive authority

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

New Hampshire

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

■ Legal authority

The New Hampshire BON grants APRNs authority to practice and regulates their practice. NPs, CRNAs, CNMs, Psych Clinical Specialists are now recognized as APRNs. APRNs do not require physician collaboration or supervision. APN SOP is defined in statute. 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; however, this is institutionally driven. The minimum academic degree required to enter into practice is a master's degree in nursing and national certification by a BON-recognized certification agency is required.

■ Reimbursement

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

■ Prescriptive authority

BON-licensed APRNs have plenary authority to prescribe controlled and noncontrolled drugs. APRNs are assigned a DEA number on request and after licensure as an APRN and are authorized to request, receive, and dispense pharmaceutical samples. Prescription labels are labeled with the APRN name.

New Jersey

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

■ Legal authority

The New Jersey BON grants APNs the authority to practice and regulates their practice. APNs are defined as NPs, CNSs, and CRNAs. 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; however, this is not defined by statute or regulation. Privileges are determined through the credentialing/privileging process of individual healthcare institutions. APN applicants must be masters prepared in nursing, and national board certification is required to enter into practice in New Jersey.

■ Reimbursement

Private health plans, including Medicaid-managed-care plans, are permitted to credential APNs as "PCPs," but not required to recognize or reimburse them. Once the APN has been credentialed by or 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, NJ Medicaid, NJ FamilyCare, United Healthcare and other Medicaid HMOs, 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 Psych APNs. Note that direct reimbursement to APNs is also provided by the Civilian Health and Medical Program (uniformed service members and their families). Where APNs are credentialed and directly reimbursed by private insurers, it is generally at 85% of the physician rate, mirroring Medicare.

■ Prescriptive authority

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

a state-controlled dangerous substance number and a federal DEA number, and have modified the joint protocol to indicate whether or not prior consultation with the collaborating physician is necessary before initiating CDS prescriptions. All APNs in New Jersey must complete a one-time 6-hour course in controlled substance prescribing. APNs are authorized to request, receive, and dispense pharmaceutical samples.

New Mexico

<http://www.nmna.org/>
<http://www.nmnp.org>

■ Legal authority

The New Mexico BON grants APRNs the authority to practice and regulates their practice. APRNs are defined as CNPs, CRNAs, and CNSs. CNPs practice independently without physician supervision or collaboration requirements. CNP SOP is defined in statute 61.3.23.2 of Chapter 61, Article 3 of the New Mexico Statutes. CNPs are statutorily recognized as PCPs; however, New Mexico does not have "any willing provider" language contained within the statutes. CNPs are legally authorized to hold admitting and hospital privileges. A master's degree in nursing or higher and national board certification is required to enter into practice as a CNP. The BON also regulates CRNAs and CNSs. CRNAs seeking initial licensure must be at the master's level or higher. CRNAs work in collaboration with a physician and have Rx authority including Schedules II-V controlled substances. CNSs must be masters prepared and certified by a national certifying nursing organization. CNSs "make independent decisions"; have "prescriptive authority," including Schedules II-V controlled substances; and can distribute prepackaged drugs. CNMs are regulated by the Department of Health. CNPs can serve as "acute, chronic, long-term, and end-of-life healthcare providers."

■ Reimbursement

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

■ Prescriptive authority

CNPs have full, independent prescriptive authority, including Schedules II-V controlled substances. BON prerequisites to prescribe controlled substances include experience

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

New York

<http://www.nysed.gov/>
<http://www.thenpa.org/>
<http://www.nysna.org>

■ Legal authority

The New York State Education Department grants NPs authority to practice and regulates their practice pursuant to Title VIII, Article 139 of NYS Education Law. APNs are defined as NPs. NPs are licensed as RNs by the BON and certified by the State Education Department as NPs. NPs are legally required to practice in collaboration with physicians in accordance with a written practice agreement and written practice protocols. NP SOP is defined in statute. NPs are considered autonomous, independent practitioners who are authorized to diagnose, treat, pathology exclusively in a State Education Department designated specialty area, in accordance with a collaborative practice agreement. The written agreement must include a provision for dispute resolution between the NP and the physician and provisions for a review by the collaborating physician of a patient record sample at least every 3 months. NPs are legally authorized to hold admitting privileges. A master's degree in nursing is required to enter into practice; however, national board certification is not required.

■ Reimbursement

NPs of all specialties may register as Medicaid providers, including mental health NPs, and be reimbursed at 100% of the physician rate. Nurses continue to be qualified providers and NPs are specifically mentioned as qualified "primary care gatekeepers." A law regulates

the practice of HMOs: Provisions are provider-neutral and apply equally to physician and nonphysician providers. Although there is no guarantee that APNs will have a role in managed-care delivery, their rights are assured. The law also prohibits "gagging" healthcare providers, establishes due process for termination of provider contracts, allows for access to specialty providers, includes continuity of care provisions for ongoing care with providers outside of the plan, and requires the commissioner of health to determine that there are sufficient providers to meet the covered patients' needs. "Willing Provider" legislation has been proposed; the public health law would specify "No HMO shall discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing, capable, and can meet the terms and conditions for participation." NPs are included in the NYSHIP Empire Plan (Insures 122,000 NYS Employees and their families) offered by the two largest State Employees Unions.

■ Prescriptive authority

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

North Carolina

<http://www.ncbon.com>
<http://www.ncnurses.org/>

■ Legal authority

The North Carolina BON and the North Carolina Medical Board jointly grant NPs the authority to practice and regulate their practice. CRNAs and CNSs are regulated by the BON only. APRNs are defined as NPs, CRNAs, CNSs, and CNMs. The BON requires that all APRNs maintain a current unencumbered RN license. NPs legally practice under a supervisory relationship with a physician; however, this is referred to as a collaborative practice agreement. Collaborative practice must include a WCPA with a physician for continuous availability, not necessarily on site, and ongoing supervision, consultation, collaboration, referral, and evaluation. After the first 6 months of NP practice, in which

documented monthly meetings are required, NPs and physicians meet at least twice a year. The CPA also includes the drugs, devices, medical treatments, tests, and procedures that may be prescribed, ordered, and performed by the NP as well as a plan for emergency services. State law does not prohibit NPs from holding admitting and hospital privileges; however, these are granted on a facility-by-facility basis. New NPs must have a master's degree or higher in nursing or in a field with primary focus on nursing and national board certification is required to enter into practice. CRNAs are regulated solely by the BON and do not have prescriptive authority. CNMs have their own separate statute and are regulated by a Midwifery Joint Committee. Although the CNS title is not protected in law or rule, CNS voluntary recognition requiring a master's degree and master's level certification and CNS SOP is regulated by the BON, but does not include prescriptive authority. CNSs with master's degrees in psychology/mental health may independently practice psychotherapy. All APRNs are allowed to form corporations with physicians; however, CRNAs can only incorporate with anesthesiologists.

■ Reimbursement

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

■ Prescriptive authority

NPs and CNMs have full prescriptive authority, including Schedules II-V controlled substances that are identified in their CPA. Dispensing may be done under specific conditions and if a dispensing license has been obtained. NPs/CNMs may refill legend drugs up to 1 year and may write controlled substance prescriptions for 30 days. Refills may be authorized according to federal DEA regulations. NPs/CNMs with controlled substances in their collaborative practice agreements must obtain a DEA number (in addition to their approval number issued at the time of their approval as NPs/CNMs).

North Dakota

<http://www.ndbon.org>

■ Legal authority

The North Dakota BON grants APRNs the authority to practice and regulates their practice. APRNs are defined as NPs, CNSs,

and NMs. NPs practice independently in North Dakota. The SOP for a NP is based upon the Decision-Making Model and as defined in the population focus certification. NPs are required to submit a SOP statement for review by the BON to apply for and renew their APRN license. APRN applicants for initial licensure must have a master's degree with completion of an advanced practice track and national board certification.

■ Reimbursement

FNPs, PNs, and CNMs receive Medicaid reimbursement at 75% of the physician rate and CNMs at 85% of the physician rate. BCBSND reimburses CRNAs, CNMs, CNSs, and NPs based on the lesser of the (1) provider's billed charges or, (2) 75% of the BC/BS physician payment system in effect at the time the services are rendered. New legislation passed in 2009 grants 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 the following cities: Williston, Dickson, Minot, Bismarck, Jamestown, Devils Lake, Grand Forks, Wahpeton, and Fargo shall be reimbursed the lesser of (1) provider's billed charges or, (2) 85% of the BCBSND physician payment system(s) in effect at the time services are rendered.

■ Prescriptive authority

Authorized APRNs may prescribe legend drugs and Schedules II-V controlled substances. For prescriptive authority, the APRN must submit an application to the BON and meet the requirements outlined in NDAC section 54-05-03.1-09. The collaborative agreement requirement for prescriptive authority was eliminated through legislation in 2011. APRNs with prescriptive authority may apply for a DEA number.

Ohio

<http://www.nursing.ohio.gov>
<http://www.oaapn.org/>

■ Legal authority

The Ohio BON grants APNs the authority to practice and regulates their practice. APNs are defined as CNPs, CRNAs, CNMs, and CNSs. Legal authority to practice requires a collaborative practice arrangement between a physician and a CNP, CNM, or CNS, in the form of a standard care arrangement (practice agreement). CRNAs are required to practice with a supervising physician. The SOP for CNPs is defined in statute, ORC 4723.43. APNs

are statutorily recognized as providing "primary care services." Currently, CNPs, CNSs, and CNMs do not have legal authority to admit patients; however, many hospitals allow APNs to hold hospital privileges. Applicants for licensure must have a master's degree in nursing or a related field that qualifies the individual to sit for the national certifying exam and hold national certification to enter into practice.

■ Reimbursement

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

■ Prescriptive authority

Ohio state law grants full prescriptive authority to qualified CNPs, CNMs, and CNSs on a voluntary basis, which includes Schedules II-V controlled substances under rules and in collaboration with a physician. A separate approval process is required to apply for prescriptive authority following a 1,500-hour externship period after graduation from an APN program. APNs with prescriptive authority in another state who meet Ohio's BON requirements may be permitted to waive this requirement. APNs prescribe based upon a formulary developed and approved by the Interdisciplinary Committee on Prescriptive Governance. APNs are not permitted to prescribe newly released drugs until the Committee has reviewed them, and those who wish to prescribe drugs for off-label use must include parameters for off-label use in the standard-care arrangement. Schedule II controlled substances are limited to the care of terminally ill patients after physician initiation and only for a 24-hour period. DEA registration is required. Prescriptions are labeled with the name of the prescriber. APNs with Rx authority may request, receive, sign for, and distribute sample medications within their scope and within the formulary with some restrictions.

Oklahoma

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

<http://www.ok.gov/nursing>

■ Legal authority

The Oklahoma BON grants APRNs the authority to practice and regulates their

practice. APRNs are defined as CNPs, CNMs, CNSs, and CRNAs. CNPs function independently with the exception of prescriptive authority, which requires supervision by a physician. APRNs practice within a SOP as defined by the NPA. The SOP for a CNP is defined in regulation and is further identified in specialty categories that delineate the population served such as Adult-Gerontology, Family/Individual across the Lifespan, and so forth. CNPs are listed as "primary care managers" in the Oklahoma Medicaid system. Authorization to admit patients or hold hospital privileges was not reported in this survey. CNSs must hold a master's degree in nursing, and CNPs and CNSs must be nationally board certified to enter into practice.

■ 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 does recognize CNPs as providers. Negotiation continues with other third-party insurers.

■ Prescriptive authority

The BON regulates optional prescriptive authority for CNPs, CNSs, and CNMs, which includes controlled substances Schedules III-V. Physician supervision is required for the prescriptive authority portion of advanced practice. Prescribing parameters include: (1) not be on the exclusionary formulary approved by the board, (2) must be within the CNP, CNM, and CNS SOP, (3) include Schedules III-V controlled substances (30-day supply) if state opioids and DEA registrations are obtained, and (4) include signing to receive drug samples. CNPs, CNMs, and CNSs must have 45 contact hours or 3 academic hours of pharmacology in the 3 years immediately preceding the initial application for Rx authority and 15 contact hours or 1 academic hour every 2 years for renewal. CRNAs have authority to "order, select, obtain, and administer legend drugs, Schedules II-V controlled substances, devices, and medical gases, when engaged in pre-anesthetic preparation and evaluation, anesthesia induction, maintenance and emergence, and post-anesthesia care." Regulation is by the BON. The CRNA functions under the supervision of a medical physician, DO, podiatric physician, or dentist licensed in Oklahoma and under conditions in which timely on-site consultation by such medical physician, DO, podiatric physician, or dentist is available. CRNAs must obtain state opioids and DEA registrations to order Schedules II-V controlled substances.

Oregon

<http://www.oregon.gov/OSBN>

<http://npo.oregonrn.org/>

■ Legal authority

The Oregon BON grants the authority to practice and regulates NPs (CNMs are a category of NP) CNSs, and CRNA. Nurses in all the three categories of advanced practice must be credentialed with a certificate by the BON. APNs in Oregon are independent. SOP is defined in regulation, Division 50 and 56 of the NPA. Division 56 addresses prescriptive and dispensing authority for both NPs and CNSs. NPs are statutorily recognized as PCPs and permissive statutes allow for NP hospital privileges. NPs may, however, be refused privileges only on the same basis as other providers. A master's degree in nursing or doctoral degree in nursing is required for the CNS and the NP or CRNA educated after specific dates (see regulations for further information). National board certification is required to enter into practice as of January 1, 2011.

■ Reimbursement

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

■ Prescriptive authority

Regulation of Rx authority is under the sole authority of the BON. Oregon has legislated independent or plenary authority for NPs to prescribe, so NPs are able to obtain DEA numbers for Schedules II-V. NPs with prescription-writing authority may receive and distribute prepackaged complimentary drug samples. NPs may apply to the BON for drug-dispensing authority if the NP's patients have financial or geographic barriers to pharmacy services. NPs do not have authority to prescribe under the physician-assisted suicide law. Only physicians can authorize medical marijuana use.

Pennsylvania

<http://www.dos.state.pa.us/nurse>

<http://www.pacnp.org>

■ Legal authority

The Pennsylvania BON grants CRNPs authority to practice and regulates their practice. A CRNP performs the expanded role in collaboration with a medical or osteopathic physician. Collaboration is defined as a process in

which a CRNP works with one or more physicians to deliver healthcare services within the scope of the CRNP's expertise. The CRNP's SOP is defined in statute and regulation. CRNPs are recognized as PCPs by DPW and many insurance companies but there are some managed-care companies who do not recognize CRNPs as PCP. The Pennsylvania Department of Health Regulations authorizes a hospital's governing body to grant and define the scope of clinical privileges to individuals, with advice of the medical staff. After February 5, 2005, CRNPs must have a master's degree and pass a national certification exam; CRNPs without a master's degree/certification are accepted if their CRNP was granted prior to the law's effective date. Regulations pertaining to the CNS have been published as final in July for certification for the CNS. The BON does not track, monitor, or license CRNAs. The BOM licenses and regulates CNMs.

■ Reimbursement

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

■ Prescriptive authority

The BON confers prescriptive authority, including Schedules II-V controlled substances, to CRNPs with a collaborating physician. Regulations allow a CRNP to prescribe and dispense drugs if the CRNP has successfully completed a minimum of 45 hours of course work specific to advanced pharmacology and if the prescribing and dispensing is relevant to the CRNP's area of practice, documented in a collaborative agreement, and not from a prohibited drug category. The CRNP may write a prescription for a Schedule II controlled substance for up to a 30-day supply. CRNPs may prescribe Schedules III-IV medications for up to a 90-day supply. CRNPs are authorized to request, receive, and dispense pharmaceutical sample medications. Prescription blanks must include the name, title, and Pennsylvania certification number of the CRNP. The collaborative agreement is a signed, written agreement between the CRNP and a collaborating physician in which they agree to the details of their collaboration including the elements in the definition of Collaboration.

Rhode Island

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

■ Legal authority

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

■ Reimbursement

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

■ Prescriptive authority

Rhode Island requires a collaborative practice agreement for prescriptive authority. CRNPs are authorized to apply for controlled substance registration for privileges to prescribe legend and Schedules II-V controlled substances. Prescriptive authority registration requires 30 hours of pharmacy CE within 3 years prior to application, Advisory Committee approval, and written collaborative guidelines with a physician. The CRNP and collaborating physician or medical director develop practice guidelines, which determine the drugs that will be prescribed from the formulary; the practice guidelines are kept at the practice site. PCNSs have authority to prescribe certain legend medications and controlled substances from Schedule II classified as stimulants and controlled substances from Schedule V that are described in regulations. PCNSs prescribe in accordance with annually updated practice guidelines, written in collaboration with the medical director or physician consultant of their individual establishments. Draft guidelines "provide guidance to licensed healthcare

facilities relating to the proper storage, security, and dispensing of medications." The guidelines, referenced from state statutes, state that licensed practitioners with authority to prescribe medications may procure and dispense (including drug samples) legend medications and Schedules II-IV controlled substances if the practitioner has obtained the required state and federal registrations.

South Carolina

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

<http://www.scnurses.org/>

■ Legal authority

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

■ Reimbursement

All NPs, regardless of specialty, may apply for a Medicaid provider number (now the NPI number), are paid 85% of the physician payment rate, and are recognized as "PCPs." The State Health and Human Services finance commissioner requires that NPs have current, accurate, and detailed treatment plans. Approximately 23 payers recognize, enroll, and directly reimburse APRNs for services provided. Dr. Stephanie Burgess, the first APRN to sit on the advisory board for State Health and Human Services Board in SC—rest of Board are MDs.

■ Prescriptive authority

APRNs have prescriptive authority, including Schedules III-V controlled substances, and prescribe according to practice agreement/protocol within the specialty area of the APRN. The BOP has opined that, "The supervising physician is not the prescriber.

The NP prescribes independently of the supervising physician, has their own DEA registration, and must have a state and federal ID number." The BON issues an ID number to the nurse authorized to prescribe. State law requires prescriptions by NPs be signed by the NP, contain the NP's BON-assigned prescriptive authority number and place of practice, and the physician's name and address preprinted on the prescription blank. APRNs with prescriptive authority may request, receive, and sign for professional samples, including Schedules III-V controlled substances.

South Dakota

<http://www.nursing.sd.gov>

■ Legal authority

The South Dakota BON and BOM jointly regulate the practice of CNPs and CNMs. APNs are defined as CNPs, CNMs, CRNAs, and CNSs. CNPs and CNMs practice in collaboration with a physician licensed in the state when performing overlapping functions between advanced practice nursing and medicine. On-site physician collaboration occurs no less than twice each month unless a modification request is approved to allow one of the twice-monthly meetings held by the telecommunication. CNSs are regulated by the BON and physician supervision is not required; however, before ordering durable medical equipment or therapeutic devices, CNSs must collaborate with a physician. CRNAs are regulated by the BON and perform acts of anesthesia in collaboration with a physician licensed in the state as a member of a physician-directed healthcare team. On-site supervision is not required. APNs are granted hospital privileges.

■ Reimbursement

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

■ Prescriptive authority

South Dakota's CNPs and CNMs may prescribe legend drugs and Schedules II-IV controlled substances as authorized by the collaborating physician agreement. CNPs and CNMs

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

Tennessee

<http://www.tnaonline.org>

<http://www.tnaonline.org/>

■ Legal authority

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

and these privileges are inconsistent across the state.

■ Reimbursement

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

■ Prescriptive authority

APNs that have a BON-issued certificate to prescribe may prescribe legend and schedule II-V controlled substances with an active DEA registration number. A certificate to prescribe requires master's or doctorate in nursing, preparation in specialized practitioner skills at the master's, postmaster's, doctorate, or postdoctoral level, 3 academic quarter hours of pharmacology, or its equivalent, and current certification in the appropriate nursing specialty area. APNs meeting these qualifications may sign prescriptions and/or issue medications, including controlled substance II-V medications under protocols in any practice site. The APN's script pad must have the preprinted name and address of the supervising physician and of the APN; however, the name of the physician is no longer required on the signature line. NPs may request, receive, and issue pharmaceutical samples.

Texas

<http://www.bon.state.tx.us>

<http://www.cnaptexas.org>

<http://www.texasnp.org>

■ Legal authority

The BON is authorized by the NPA to regulate APRNs. After becoming licensed as a RN (or, if not residing in Texas, practicing on a multistate privilege), all APRNs must apply to the BON for licensure to practice as an NP, CNM, CRNA, or CNS. The APRN's SOP is based on advanced practice education, experience, and the accepted SOP of the associated population-focus area. Unless NPs receive a waiver, the BON will only recognize NPs educated in nine specialties for entry into practice: (1) adult acute care, (2) pediatric acute care, (3) adult, (4) family,

(5) geriatric, (6) neonatal, (7) pediatric, (8) psychiatric/mental health, and (9) women's health. The APRN acts independently and/or in collaboration with the healthcare team. The authority to make a medical diagnosis and write Rx must be delegated by an MD or DO using written delegation protocols or other written authorization. The rules define protocols as written authorization to provide medical aspects of care. Protocols should allow the APRN to exercise professional judgment and are not required to outline specific steps the APRN must take, but they are required to contain certain elements regarding prescriptive authority. (A sample practice protocol may be purchased on CNAP's website.) 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 the physician payment. Under certain circumstances, physicians in the Texas Medicaid Program may bill for an APRN's services and receive 100%. Some programs such as Texas Health Steps reimburse all providers at the same rate. NPs can be PCPs in Texas Medicaid-managed-care plans. APRNs are listed in the Texas Insurance Code as practitioners that must be reimbursed by indemnity health insurance plans. All HMOs and PPOs in Texas must list an APRN on provider panels if the APRN's collaborating physician is on the panel and the physician requests that the APRN also be listed.

■ Prescriptive authority

APRNs must obtain a prescriptive authorization number from the BON. To receive the number, the nurse must have full licensure to practice as an APRN in Texas and meet certain additional educational requirements. To use prescriptive authority, APRNs must practice in a qualifying site and a physician must delegate prescriptive authority in that site using delegation protocols or other written authorization and report the delegation through the Texas Medical Board's website. Sites qualifying for prescriptive authority are as follows: (1) sites that serve medically underserved populations, (2) physician primary practice sites, (3) physician alternate practice sites, and (4) facility-based practices in hospitals or long-term-care facilities. The delegating physician must spend some time at each site with the APRN, but that time varies from once every 10 business days in a medically underserved population site to the majority of the time in a physician's primary practice site.

The Texas Medical Board has authority to waive many of the supervisory and site requirements for physicians who delegate prescriptive authority. The BON is not a part of this process. Physicians may delegate prescriptive authority for Schedules III-V controlled substances with the following limitations: (1) APRNs may only Rx a maximum 90-day supply, (2) the APRN must consult with the physician before authorizing a refill, (3) APRNs may not Rx controlled substances to a child under 2 years without physician consultation, and (4) physician consultation must be noted in the chart. APRNs that prescribe controlled substances must have a permit from the Texas Department of Public Safety and a DEA number. APRNs with prescriptive authority may request, receive, possess, and distribute samples of drugs they are authorized to prescribe.

Utah

<http://www.dopl.utah.gov/index.html>

■ Legal authority

The Utah BON in collaboration with the Division of Occupational and Professional Licensing grants authority to practice via licensure with an "APRN" or "APRN-CRNA without prescriptive practice" license and regulates the practice of APRNs and CRNAs. Licensed APRN categories include NPs, CNSs, psychiatric/mental health nurses, and CRNAs. CNMs are regulated by a separate practice act and CNM board. APRNs practice independently except for the act of prescribing controlled substances Schedules II-III, where a consultation and referral plan is required. The APRN SOP is defined by set standards from national professional specialty organizations, APRNs are not statutorily prohibited from admitting patients and holding hospital privileges; however, this is decided upon by the individual institution. All APRNs must hold a master's degree prepared or higher and nationally certified to obtain licensure. During the 2004 legislative session, the Utah Legislature was the first legislature to adopt the APRN compact.

■ Reimbursement

The state insurance code has a nondiscrimination code; nothing prohibits reimbursement. CNMs, APRNs, and CRNAs are reimbursed by most insurance companies. Board-certified PNP and FNPs are reimbursed by Medicaid at 100% of the physician rate. CNMs are reimbursed at 65% by Medicare, whereas other APRNs receive reimbursement at 80% of the physician rate.

■ Prescriptive authority

APRNs and CNMs have prescriptive authority for all legend drugs and devices, including Schedules IV-V controlled substances, within their SOP. A consultation and referral plan is

only needed if prescribing Schedules II or III controlled substances. APRN-CRNAs do not require a consultation or referral plan for their practice. CRNAs may order and administer drugs, including Schedules II-V controlled substances, in a hospital or ambulatory care setting; they may not provide prescriptions to be filled outside the hospital. APRNs, CRNAs, and CNMs receive a DEA number after passing a controlled substance exam and obtaining a state-controlled substance license. APRNs and CNMs may sign for and dispense drug samples.

Vermont

<http://vtprofessionals.org/opr1/nurses/>
<http://www.vtnpa.org/>

■ Legal authority

The Vermont BON grants APRNs the authority to practice and regulates their practice. APRNs include, but are not limited to, NPs in adult, pediatrics, family and women's health, CNMs, CRNAs, and CNSs in psychiatric health. The BON endorses other CNSs under certain circumstances. The APRNs are independent providers with an SOP defined in statute and regulations. APRNs are authorized to admit patients to a hospital and hold hospital privileges, according to agency protocols. APRNs are required to have a master's degree in nursing and hold national board certification to enter into practice.

■ Reimbursement

BC/BS reimburses psychiatric NPs using a provider number. All NPs receive Medicaid reimbursement at 100% of the physician payment. Although legislation requiring or prohibiting third-party reimbursement does not exist, insurance companies may reimburse NPs depending on policies.

■ Prescriptive authority

APRNs have full prescriptive authority, including Schedules II-V controlled substances within their practice guidelines. APRNs have the same privileges dispensing and administering drugs as physicians. NPs register for their own, receive DEA numbers, and are authorized to request, receive, and/or dispense pharmaceutical samples. Prescriptions are labeled with the APRN's name.

Virginia

<http://www.dhp.virginia.gov>
<http://www.vcnp.net/>

■ Legal authority

The Virginia BON and BOM have joint statutory authority to regulate licensed NPs (LNPs). Specialty NPs, CNMs, and CRNAs are included in the category of LNPs. CNSs are registered solely with the BON. The presidents

of the BON and BOM each appoint three board members to the Committee of the Joint Boards of Nursing and Medicine to administer LNP regulations. LNPs must be nationally certified to apply for state licensure. LNPs licensed in a category other than CNMs must practice under the medical direction and supervision of a physician. CNMs practice in collaboration and consultation with a licensed physician except for prescriptive authority, which still carries a statutory requirement for supervision. NP practice is based on education, certification, and a written protocol. An NP may practice within the parameters of a written protocol with a supervising physician, as defined in regulation. According to the Virginia BON, NPs are not statutorily prevented from being PCPs and no law or regulation prevents them from admitting patients to the hospital and holding hospital privileges. Virginia state law does not include NPs in its "any willing provider" language. A master's degree in nursing and national board certification is required to enter into practice in Virginia. In 2004, legislative changes were made to Virginia Code that now include NPs whenever any law or regulation requires a signature, certification, stamp, verification, affidavit, or endorsement by a physician. Among other things, NPs are also authorized to certify medical necessity of durable medical equipment that is to be reimbursed by Medicaid.

■ Reimbursement

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

■ Prescriptive authority

Authorized LNPs may prescribe all legend drugs, including Schedules II-V controlled substances as defined in the LNP's Practice Agreement. A Practice Agreement, developed between the NP and the supervising physician and submitted to the Joint Boards of Nursing and Medicine, lists the drug categories the NP will prescribe. NPs may only prescribe legend drugs if "such prescription is authorized

by the Practice Agreement between the NP and physician." The prescription must include the NP's name and prescriptive authority number, and the patient must be informed in writing of the name and address of the supervising physician. Supervision means the physician documents being readily available for medical consultation by the LNP or the patient.

Physicians who enter into a Practice Agreement with a LNP may only supervise at any one time, four NPs with prescriptive authority. Physicians who supervise NPs must regularly practice in any location where the NP exercises prescriptive authority, and conduct a regular random review of patient charts on which the NP has entered a prescription for an approved drug or device. However, physicians who practice with a CNM or with a NP employed by or under contract with local health departments, federally funded comprehensive primary care clinics, or nonprofit healthcare clinics or programs shall either regularly practice at the same location with the NP or provide supervisory services to such separate practices by making regular site visits for consultation and direction for appropriate patient management. The site visits shall occur in accordance with the protocol, but no less frequently than once a quarter.

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

Washington

<http://www.doh.wa.gov/hsqa/professions/Nursing/default.htm>

■ Legal authority

The Nursing Care Quality Assurance Commission grants APNs the authority to practice and regulates their practice. APNs are designated as ARNPs. This includes NPs, CNMs, and CRNAs. ARNP practice is independent and ARNPs assume primary responsibility for continuous and comprehensive management of a broad range of patient care, concerns, and problems. The SOP for ARNPs is defined in statute and regulation. ARNPs are statutorily defined as PCPs and are legally authorized to admit patients to a hospital and hold hospital privileges. However, hospitals and medical staff have the right to make the decision on

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

■ Reimbursement

Medicaid reimbursement is available to ARNPs at 100% of the physician payment. Labor and Industry reimbursement is at 90% of the physician payment. Washington insurance code bans discrimination against RNs, podiatrists, chiropractors, and certain mental health professionals. Rules governing payment to, and inclusion of, nurses prohibit artificial reductions in the level of an indemnification benefit based on a patient's choice of nursing services rather than those of other healthcare providers. A difference in payment between a physician and a nurse who provide the same services must result from the "disparity of fees actually charged by medical doctors and RNs rather than from an arbitrary formula based on assumptions concerning the relative worth of physician-provided services versus nurse-provided services." The law pertains to private insurers and healthcare service contractors. The law, however, has not prevented insurers from reimbursing ARNPs at a rate lower than that of physicians and efforts to contest that have failed.

■ Prescriptive authority

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

West Virginia

<http://www.wvrnboard.com>

■ Legal authority

The West Virginia BON grants authority to practice and regulates the practice of APNs. R&R define advanced practice for RNs. ANP includes NPs, CNSs, CNMs, and CRNAs. ANP SOP includes the ability to assess, conceptualize, diagnose, analyze, plan, implement, and evaluate complex problems related to health. The ANP SOP does not require collaboration with a physician unless the ANP is prescribing. The CNM is required to practice in a

collaborative relationship with a physician with or without prescriptive authority. CRNAs administer anesthesia in the presence and under the supervision of a physician or DDS. Hospital credentialing for ANPs is dependent upon individual hospital policy. All ANPs licensed after January 1, 1999, must have a master's degree in nursing and hold national board certification to enter into practice.

■ Reimbursement

Family, pediatric, gerontological, 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 nursing services, if such services are commonly reimbursed for other providers; however, rules and regulations have not been promulgated. NPs and CNMs are defined as PCPs (a person who may be chosen or designated in lieu of a primary care physician who will be responsible for coordinating the healthcare of the subscriber). The only restriction is that the NP or CNM must have a written association with a physician listed by the managed-care panel; there is no requirement for employment or supervision by the physician. The Woman's Access to Health Care Bill provided for direct access, at least annually, to a woman's healthcare provider for a well-woman exam; providers include ANPs (CNMs, FNPs, WHNPs, adult NPs, GNPs, or PNPs).

■ Prescriptive authority

Qualified ANPs and CNMs have prescriptive authority requiring a collaborative relationship with a licensed physician. Prescriptive authority includes Schedule III-V controlled substances with some restrictions. Rules and regulations specify that the ANP or CNM must meet specified pharmacology education requirements and certify that they have a written collaborating agreement with a physician or osteopath. The written collaborative agreement must include guidelines or protocols describing the individual and shared responsibility between the ANP or CNM and physician, with periodic joint evaluation of the practice and review and updating of the written guidelines or protocols. No supervision requirement exists; ANPs are not required to be employed by a collaborating physician. The ANP and CNM works from an exclusionary formulary. Schedules I and II, anticoagulants, antineoplastics, radiopharmaceuticals, and general anesthetics are prohibited. MAO Inhibitors are excluded, except when in a collaborative agreement with a psychiatrist. Additional changes include the increase in amount of CS IV and V medications that may be prescribed. A DEA number is issued directly to an ANP or CNM by the DEA and ANPs are authorized to sign for and provide drug samples.

Wisconsin

<http://www.wisconsinnurses.org/>
<http://www.legis.state.wi.us/statutes/Stat0441.pdf>

■ Legal authority

The Wisconsin BON grants APNs the authority to practice and regulates their practice. APNs are defined as NPs, CNSs, CNMs, and CRNAs. NPs function under the NPA with a broad description of nursing practice. SOP is defined in statute and regulations that cover the performance of both delegated medical acts by an RN and also the expanded role practiced by APNs by virtue of the education, training, experience, and certification. APNs are educated to exercise a high degree of independent judgment, complex decision making, and skill in managing organizations and healthcare environments. They are educated to provide services that include but are not limited to physical assessment, diagnosis, prescription of medication, and selection and performance of appropriate diagnostic and therapeutic regimens. Current state statute allows the Wisconsin BON to promote public safety while encouraging professional nurses to practice at the full level of their educational preparation, training, and experience (Contemporary SOP for Professional Nursing in Wisconsin, 1998). Hospital privilege laws are permissive, not prescriptive; therefore, some hospitals extend full admitting privileges to APNPs, others do not. An RN must have a master's degree in nursing, national APN board certification, malpractice insurance (1 million/3 million), and 45 required clinical pharmacology hours to enter into practice in Wisconsin. APNs collaborate with other healthcare providers, at least one of whom needs to be a physician.

■ Reimbursement

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

■ Prescriptive authority

RNs may prescribe legend drugs and controlled substances as a delegated medical act under the NPA. APNs may receive "Advanced Practice Nurse Prescriber" (APNP) certification from

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

Wyoming

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

■ Legal authority

The Wyoming BON grants APRNs the authority to practice and regulates their practice. APRNs are defined as NPs, CNMs, CRNAs, and CNSs. APRNs are not required to have a collaborative or supervisory relationship with a physician. The SOP of an APRN is defined in statute, within the NPA, and includes prescriptive authority and management of patients... "APRNs are statutorily defined as PCPs and may be permitted to admit patients to a hospital and hold hospital privileges, depending on individual hospital policies." A master's degree in nursing in a specific APRN role and national board certification in that role are required to enter into practice as an APRN in Wyoming.

■ Reimbursement

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

■ Prescriptive authority

BON-approved APRNs may independently prescribe legend and Schedules II-V controlled substances. APRNs are considered independent providers and register for their own DEA numbers. Additionally, APRNs who have prescriptive authority are legally authorized to request, receive, and dispense pharmaceutical samples. This is not addressed by the BON, possibly the Pharmacy Board. Prescriptions are labeled with the APRN name. **NP**