The Nurse Practitioner is proud to present the seventeenth annual update on legislative issues affecting advanced practice registered nurses (APRNs) across the country.

Each year, nurse practitioners (NPs) eagerly anticipate the publication of this expert legislative and regulatory synopsis of advanced practice nursing. This report has become highly regarded across the country for not only the NP profession, but also for regulatory agencies, state NP associations, healthcare administrations, and state legislators. This information is cited in countless state legislative hearings as a reference to legal and prescriptive authority for NPs across the nation, as each state works diligently to amend laws allowing NPs to practice at their full potential.

The following pages contain the latest regulatory and statute updates for APRNs in all 50 states and the District of Columbia.

The Nurse Practitioner journal has been able to compile this update each year for the past 17 years thanks to the tireless efforts of executives, directors, and officials from each state’s Board of Nursing, nursing associations, and NP organizations, that provide the necessary information to bring this update to you. This year’s update provides the latest data on how each state legislatively stands on issues affecting NPs, clinical nurse specialists, nurse midwives, and nurse anesthetists. There are three tables within the article to help illustrate the vast information available on every state. The “Summary of Advanced Practice Nurse (APN) Legislation: Legal Authority for Scope of Practice” explains state legislation regarding APN legal scope of practice. The “Summary of APN Legislation: Prescriptive Authority” shows the NP prescriptive and dispensing authority in the United States. Finally, the “Summary of Advanced Practice Nursing Population” presents the latest numbers from each state’s Board of Nursing of state-recognized APNs.

Professional Advancements

Good news! As with past years, great advances in the NP profession continue nationwide. Fourteen states have enacted new laws and amended existing laws affecting NP’s legal authority to practice. One state has enacted positive amendments affecting the reimbursement of NPs; and three states have enacted amendments to current law, which will positively affect prescriptive authority for NPs.

Major Advances in Legal Authority

Arizona reports that national certification is required for new NP applicants effective July 1, 2004.

A comprehensive look at the legislative issues affecting advanced nursing practice
The Nurse Practitioner • Vol. 30, No. 1

Seventeenth Annual Legislative Update

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

- States with nurse practitioner** title protection; the board of nursing has sole authority in scope of practice, with no statutory or regulatory requirements for physician collaboration, direction, or supervision: AK, AR, AZ, CO, DC, HI, IA, ID, KS, KY, ME, MI, MT, ND, NH, NJ, NM, OK, OR, RI, TN, TX, UT, WA, WI, WV, WY

- States with nurse practitioner** title protection; the board of nursing has sole authority in scope of practice, but scope of practice has a requirement for physician collaboration: CT, DE, IL, IN, MA, MD, MN, MO, NE†, NV, NY, OH, PA, VT

- States with nurse practitioner** title protection; the board of nursing has sole authority in scope of practice, but scope of practice has a requirement for physician supervision: CA, FL, GA, MA, SC

- States with nurse practitioner** title protection, but the scope of practice is authorized by the board of nursing and the board of medicine: AL, MS, NC, SD, VA

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

California passed legislation requiring a master’s degree or graduate degree in nursing for new NP applicants and those who have never been certified in any other state effective January 1, 2008, and removed all restrictions to those who have never been certified in any other state.

Connecticut passed several pieces of legislation pertaining to NPs, including APRNs to maintain registered nurse licensure, and enabling APRNs to pronounce and certify death and certify disability so that patients can apply for a disabled license plate or placiard. The Idaho State Legislature passed an amendment to the Nursing Practice Act that removed the requirement for physician supervision as a condition of practice for NPs, certified nurse midwives, and clinical nurse specialists; it further amends the Act to require completion of a peer review process as a condition of licensure renewal. Iowa’s Nurse Practice Act was amended to authorize registered nurses to execute the regimen prescribed by NPs and physician assistants, in addition to physicians. Maryland reports new legislation that authorizes psychiatric NPs and psychiatric/mental health clinical nurse specialists to file and present a petition for an emergency evaluation of an individual. Missouri enacted title protection for APRNs, and North Dakota’s Board of Nursing promulgated regulations defining APRN standards and scope of practice. Oklahoma extended APRN’s scope of practice to include the ability to write for handicapped parking placards. Pennsylvania’s state legislature amended their Vehicle Code to include NPs and those who have never been certified in any other state (excluding controlled substances) with some degree of physician involvement or delegation of prescriptive authority. In Pennsylvania, the state legislature passed a bill that was signed into law giving APNs authority to initiate controlled substance prescription orders (in accordance with joint protocols) in all circumstances, without current restrictions. North Dakota’s NPs now have the authority to prescribe, administer, sign for, dispense, and procure pharmaceutical samples following state and federal regulations.

The Big Picture

As states continue to make important changes, it is imperative that NPs begin to turn their focus outward, look at best practice models of delivering healthcare, and look for opportunities locally, statewide, and nationally to develop these practices. This process requires a different professional mindset than the traditional “chip away at the practice barriers” model that so many states have focused on over the past 30 years in order to gain professional autonomy. An example is the concept of collaborative or team-based practice. These models of practice must be developed and implemented using a professional collaborative approach, rather than the standard physician-supervised model. Nurse practitioners are the experts in collaboration, and are uniquely positioned to have a key role in designing health-care systems that recognize the expertise of all healthcare disciplines equally. As NPs and professional organizations move forward in their efforts to attain professional autonomy, it is important that NPs capitalize on our unique professional strengths.

ACKNOWLEDGMENT

On behalf of nurse practitioners nationwide, I would like to thank Linda Peeran, RN, MSN, ENP-C, FNP-C, DNP, for her previous efforts on The Nurse Practitioner’s Annual Legislative Update. While every attempt has been made to present the most current information possible, we welcome your feedback and will print valid corrections and updates.

California passed legislation requiring a master’s degree or graduate degree in nursing for new NP applicants and those who have never been certified in any other state effective January 1, 2008, and removed all restrictions to those sites where NPs could prescribe. Additionally, the successful legislation granted the Board of Registered Nursing sole authority to define and regulate the practice of nursing in 2004.

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## Summary of Advanced Practice Nurse Population*

<table>
<thead>
<tr>
<th>State</th>
<th>Total Number of Advanced Practice Nurses</th>
<th>Nurse Practitioners</th>
<th>Clinical Nurse Specialists</th>
<th>Certified Nurse Midwives</th>
<th>Certified Registered Nurse Anesthetists</th>
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<td><strong>Total</strong></td>
<td>174,606</td>
<td>115,091</td>
<td>14,066</td>
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* Numbers are provided by state BON authorities. The numbers may include duplicate licenses within one state or multistate licenses. The numbers reflect state APN recognition only and may not reflect active employment status.

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

† Psychiatric specialty only.

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

§ Numbers reflect only APNs with prescriptive authority.
Alabama

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

Legal Authority

The BON is the sole state authority to establish the qualifications and certification requirements through R&R for APNs (CRNPs, CNMs, CRNAs, and CNSSs). The APN shall practice in accordance with national standards and functions identified by the appropriate specialty-certifying agency and as congruent with Alabama law. Initial CRNP applicants are exempt from requirement for MSN on discretion of the BON, if graduation was before 1996 in post-BSN NP program, or graduation before 1984 from non-BSN program preparing NPs. The BON and BOME regulate (through R&R) the collaborative practice of physicians and CRNPs and CNMs, and require them to practice with BON- and BOME-approved protocols. The protocol must include a formula for drugs, treatments, tests, and procedures; a preoperative protocol for emergency services; a referral process; mechanisms for quality analysis; and a written plan for review of medical records. 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 BOME and BON.” The collaborating physician shall be present in a practice site a minimum of 10% per month (if the CRNP’s or CNM’s collaboration time is 30 or more hours per week) and a minimum of 10% on a quarterly basis (if the collaboration time is less than 30 hours per week). CNSSs and CRNAs are not regulated by the joint committee (BON and BOME), and are not eligible for prescriptive authority. Effective January 1, 2004, the BON approved the practice of CRNAs, if they have earned a minimum of a master’s degree from an accredited nurse anesthesia graduate program and are currently certified as a CRNA; CRNAs who graduated prior to December 31, 2003, are exempt from the master’s degree requirement. After January 1, 2005, CNS approval requires MSN as a CNS and national certification. After December 31, 2004, national certification is required for approval or renewal as a CNS.

Reimbursement

The state BC/BS is the administrator of the State Employees Insurance Benefits plan (SEIB). The state nursing association is working with the SEIB to improve and expand NP reimbursement. There are no legislative restrictions against APNs or CRNPs on managed care panels. The Alabama Medicaid Nurse Practitioner Program reimburses NPs; Alabama Medicaid does not reimburse for services provided in a hospital or emergency department. NPs are reimbursed through the KidsFirst Program.

Prescriptive Authority

CRNPs and CNMs may “prescribe, administer, and provide therapeutic tests and drugs” within an approved formulary. A BON and BOME joint committee (composed of one CNM, CRNP, and RN and three physicians) recommends R&R governing the collaborative relationship between physicians and CRNPs and CNMs and the prescription of legend (noncontrolled) drugs. The R&R specify a 2:1 ratio (CRNP:MD) and a 3:1 ratio (CNM:MD) or a combination of CRNP and CNM:MD. Exemptions to this specification include public health employees and practices in place before R&R took effect. The joint committee considers applications for ratio exemptions. The BON and BOME shall approve the protocols and formulary of legend drugs that may be prescribed by authorized CRNPs and CNMs. Authorization is tied to the collaborative agreement; if CRNPs or CNMs change physicians, they must reapply. The CRNP or CNM is issued a 4-digit Rx number by the BON; the Rx pad must include the physician name and address, and the CRNP or CNM name, RN license number and Rx number. The CRNP or CNM who is in collaborative practice and has Rx privileges may sign for and dispense approved formulary drugs.

Legislative Update Key

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<th>ACNP</th>
<th>CRNP</th>
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• Certification (by a nationally recognized accrediting agency for this specialty)
• For each state’s Medicare carrier, access the CMS Web site: http://cms.hhs.gov/providers/enrollment/contracts/
ANPs are authorized under regulations adopted by the BON to dispense medications.

Arizona

http://www.azboardofnursing.org

■ Legal Authority
A Registered Nurse Practitioner (RNP) is defined in the NPA statute; corresponding R&R outline the scope of practice. RNPs include Nurse Practitioners (NPs) and Certified Nurse Midwives (CNMs). RNPs have a statutory defined scope of practice, which includes (1) assessing clients, synthesizing and analyzing data, and understanding and applying principles of healthcare at an advanced level; (2) managing the physical and psychosocial health status of clients; (3) analyzing multiple sources of data, identifying alternative possibilities as to the nature of a healthcare problem and selecting, implementing, and evaluating appropriate treatment; (4) making independent decisions in solving complex client care problems; (5) diagnosing, performing diagnostic and therapeutic procedures, prescribing, administering, and dispensing therapeutic measures, including legend drugs, medical devices, and controlled substances within the scope of RNP practice on meeting the requirements established by the BON, and (6) referring clients to other healthcare providers when appropriate. CNSs must have a master’s degree in nursing; they are not allowed to prescribe legend drugs or controlled substances. Recent legislation requires national certification for new NP applicants, effective July 1, 2004.

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

■ Prescriptive Authority
RNPs have full prescriptive and dispensing authority, including controlled substances schedule II-V, on application and fulfillment of BON-established criteria. RNPs prescriptive and dispensing authority is linked to the RNP’s scope of practice (e.g. according to the BON, prescribing to an adult is outside of a PNP’s scope). Prescribing without documenting an examination is considered by the BON to be a violation of the NPA. The pharmacy statute enables RNPs to prescribe, with corresponding R&R in the NPA. No annual CEU documentation is required for renewal of prescriptive and dispensing authority. An RNP with prescriptive and dispensing authority who wishes to prescribe a controlled substance must apply to the DEA for a registration number and file this number with the BON. Drugs, other than controlled substances, may be refilled up to 1 year. CRNAs may prescribe drugs to be administered by a licensed certified or registered healthcare provider preoperatively, postoperatively, or as part of a procedure; CRNAs are not authorized to dispense.

Arkansas

http://www.arsbn.org

http://www.ama.org/

■ Legal Authority
The NPA provides second licensure by the BON for Advanced Practice Nurses (APNs) who are nationally certified in one of four categories: CNM, CNS, CRNA, or NP. R&R provide for scope of practice as defined by the national certifying body. A consulting physician is only required for CNMs providing intrapartum care. NPs not nationally certified for licensure as an RNP and practice under physician direction/protocol. Graduate-level APN education was required for initial APN licensure after January 2003, however, there are provisions for licensure by endorsement for APNs without graduate degrees. The CRNA scope of practice is defined as the administration of anesthetics under the supervision of, but not necessarily in the presence of, a physician or DDS; CRNAs may order RNs to administer drugs pre- and postoperatively for any procedure that has been/will be provided. If the hospital/institution authorizes the CRNA to act as its agent under its DEA number, the physician need not sign the orders. Hospital privileges for APNs are determined on a hospital-to-hospital basis, according to the credentialing committee of each hospital.

■ Reimbursement
The NPA mandates direct Medicaid reimbursement to APNs and RNPs, with the exception of Adult, Acute Care and Psychiatric Mental Health NPs. Medicaid reimbursement is 80% of physicians’ rates. APNs are not recognized as PCPs for Medicaid. BC/BS reimburses ANPs who have a collaborative practice agreement. Services are filed under the collaborative physician’s name and are paid at the physician’s rate. Reimbursement is limited to E&M Codes 99203 and 99213 and below. CNMs and some NPs are listed on managed care panels. A statutory provision exists for third-party reimbursement for CRNAs.

■ Prescriptive Authority
The NPA authorizes the BON to provide a certificate of Rx authority 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 Rx authority. Under R&R, an initial applicant for Rx authority must (1) be an APN with completion of pharmacology coursework of 3 graduate credit hours or 45 contact hours in a competency-tested pharmacology course; (2) have 300 hours of precepted prescribing experience; (3) have 1,000 hours of post-APN education program experience; and (4) include a collaborative practice agreement with a physician. Endorsement applicants must provide Rx evidence of at least 1,000 hours in the last year and have a clear DEA history. This Rx authority includes Schedules III-V controlled substances after a DEA number is obtained. APNs who have fulfilled requirements for Rx authority may receive legend drug samples and therapeutic devices appropriate to their area of practice, including Schedules III-V controlled substances. A 2001 attorney general decision opined that APNs with Rx authority have implied authority to give sample Rx drugs to patients.

California

http://www.m.ca.gov/

http://www.canpweb.org

■ Legal Authority
The California Board of Registered Nursing (BRN) issues separate certification to NPs, CNMs, CRNAs, and CNSs. Advanced practice titles are protected and recent legislation defined them as Advanced Practice Registered Nurses (APRNs). Legislation in 2004 requires all NPs entering practice after January 1, 2008 to hold a master’s degree in nursing, other master’s degree in a clinical field related to nursing or a graduate degree in nursing. NPs function under “standardized procedures” or protocols when performing medical functions. The standardized procedures shall (1) be in writing and signed by the authorized organized healthcare system personnel, (2) specify which standardized procedure functions may be performed, (3) specify state requirements that are to be followed, (4) specify experience, training, and/or education requirements for performance of a procedure, (5) establish a method of evaluation, (6) specify the scope of supervision for the persons authorized to perform the procedure functions, (7) specify the circumstances that require immediate communication with the patient’s physician, and (8) specify record keeping and periodic review requirements. The standardized procedures are agency-specific and must meet certain requirements, including collaborative development by nursing, medicine, and the administration within the agency. The level of “supervision” required is specific to the practice setting as specified in the standardized procedure. Supervision does not require the physical presence of a physician. CNMs under supervision of a physician with a current obstetrics practice attend normal childbirth and provide prenatal, interpartum, and postpartum care. “Supervision” does not require the physical presence of the physician.
Colorado
http://www.dora.state.co.us/nursing

Legal Authority
Definitions in the NPA are broad; scope of practice is based on the individual nurse’s knowledge, judgment, and skill. Title protection is provided for Advanced Practice Nurses (APNs), which include nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse midwives (CNMs) and certified registered nurse anesthetists (CRNAs). Use of APN titles requires BON registration. NPs can be admitted to the Advanced Practice Nurse Registry upon successful completion of a nationally accredited educational program for preparation as an advanced practice nurse or a passing score on a certification exam of a nationally recognized accrediting agency. After July 1, 2008, a graduate degree in a nursing specialty will be the minimum degree requirement. APN scope of practice is founded on the relevant educational program and core curriculum as determined by accepted professional standards. Although a function may be within an APN’s scope, the individual APN must have the requisite knowledge, judgment, and skill to safely and competently perform any undertaken function. As of 2001, a CNM shall have “a safe mechanism for consultation or collaboration with a physician or, when appropriate, referral to a physician.”

Reimbursement
Third-party reimbursement is available to any RN; billed services qualify for reimbursement only if the type of service has a history of being reimbursable to other healthcare providers. No statutes or rules prohibit or constrain APNs in managed care. Medicaid reimbursement is available to PNPs, FNPs, CNMs, and CRNAs.

Prescriptive Authority
Prescriptive authority statutes include prescription drugs. Schedules II-V controlled substances are approved after receiving a DEA number. For prescriptive authority eligibility, the prescribing nurse must be listed on the APN registry and have a post-basic or graduate degree in a nursing specialty that includes at least 45 contact hours in health assessment, pharmacology, and pathophysiology. The APN must have satisfactorily completed education in the use of controlled substances and prescription drugs, have postgraduate experience as an APN in a relevant clinical setting of no less than 1,800 hours (in the immediately preceding 5-year period), and have a written collaborative agreement with a physician whose medical education and active practice correspond with that of the APN. The written collaborative agreement shall include the duties and responsibilities of each party, provisions regarding consultation and referral, a mechanism designated by the APN to ensure appropriate prescriptive practice, and other provisions established by the board. The APN shall provide the BON with the collaborating physician’s name; that information will also be available to the BOP, BOM, and (except for DEA numbers) the public. APN law states that nothing shall be construed to limit the ability of the APN with prescriptive authority to make independent judgments, require supervision by a physician, or require the use of formularies. APNs with prescriptive authority may dispense or distribute drug samples pertaining to their area of specialty practice.

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

Legal Authority
The NPA defines Advanced Practice Registered Nurses (APRNs) as Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), and Certified Registered Nurse Anesthetists (CRNAs). Use of APNs to work in collaborative relationships with physicians, R&R specific to this law have not been written. Connecticut law defines collaboration as a mutually agreed on relationship between an APRN and a physician who is educated, trained, or has experience related to an APRN’s work. The collaboration between the physician and the APRN must include (1) reasonable and appropriate consultation and referral, (2) patient coverage in the absence of the APRN, (3) a method for reviewing patient outcomes, and (4) a method of disclosing the collaborative relationship to the patient. Current law exempts CRNAs, as their service is under the direction of a licensed physician. The 1999 NPA may be further revised to clarify: (1) Must an APRN also be a current licensed RN in the state? At this time, the APRN needs only “to be eligible for a license.” Recent clarification of the NPA authorizes RNs to continue to operate under an order issued by an APRN. Certified Nurse Midwife scope of practice is recognized under a separate 1984 statute.

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

Prescriptive Authority
APRNs working in a collaborative relationship with a physician may prescribe, dispense, and administer medications, including Schedules

Prescriptive Authority
NPs and CNMs may furnish or “order” drugs or devices when (1) the drugs or devices are furnished or ordered by an NP or CNM in accordance with standardized procedures. The act of “furnishing” is the same as the act of prescribing. Furnishing does not require the physical presence of the physician. Physician supervision includes collaboration on the development and approval of the standardized procedure and physician availability by electronic means. Pharmacists must include both the NP’s or CNM’s and physician’s name on the drug label, however, after January 1, 2005, the physician’s name will no longer be required by law to appear on the prescription label. NPs and CNMs may sign for, request, and receive pharmaceutical samples and may dispense drugs, including controlled substances pursuant to a standardized procedure or protocol. A physician or surgeon shall not supervise more than four NPs or CNMs at a time for the purposes of prescribing. After January 1, 2004, NPs were legally authorized to prescribe Schedule II controlled substances pursuant to a patient-specific protocol that addresses the diagnosis of illness, injury, or condition for which the Schedule II medication is prescribed. This legislation added CS II privileges to the existing CS III-V authority granted in 1997. NPs authorized by the BRN to furnish or order controlled substances are authorized to register for a DEA number. CNMs may furnish or order noncontrolled medications and Schedules III-V controlled substances within a patient-specific, physician-approved standardized procedure or protocol in practice settings (including licensed birth centers). CNMs may furnish Schedule II controlled substances only in a licensed acute care hospital. CNMs must register with the DEA. To obtain a DEA-issued furnishing number, NPs and CNMs must complete a qualifying pharmacology course and 520 hours of physician-supervised experience within 8 to 12 months.

Reimbursement
Medi-Cal (California’s Medicaid Program) reimburses FNPs, PNPs, CNMs, and CRNAs for Medicaid-covered services at the same rate as physicians. Blue Cross of CA Medi-Cal Provider Directory lists NPs as PCPs under their area specialty. There is no legal preclusion to third-party reimbursement of NP services, however, policies vary from payer to payer. Third-party payers are 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. NPs, CNMs, and CRNAs may be professionally exempt from mandatory overtime in the labor code, providing the definition for “professional” in the labor code is met.

Legal Authority
Definitions in the NPA are broad; scope of practice is based on the individual nurse’s knowledge, judgment, and skill. Title protection is provided for Advanced Practice Nurses (APNs), which include nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse midwives (CNMs) and certified registered nurse anesthetists (CRNAs). Use of APN titles requires BON registration. NPs can be admitted to the Advanced Practice Nurse Registry upon successful completion of a nationally accredited educational program for preparation as an advanced practice nurse or a passing score on a certification exam of a nationally recognized accrediting agency. After July 1, 2008, a graduate degree in a nursing specialty will be the minimum degree requirement. APN scope of practice is founded on the relevant educational program and core curriculum as determined by accepted professional standards. Although a function may be within an APN’s scope, the individual APN must have the requisite knowledge, judgment, and skill to safely and competently perform any undertaken function. As of 2001, a CNM shall have “a safe mechanism for consultation or collaboration with a physician or, when appropriate, referral to a physician.”
II–V controlled substances that are expressly specified in the written collaborative agreement. The prescription form must include the name, address, and phone number of the APRN or CNM and can include the collaborative practitioner’s name. 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 subscriber 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 regulation and the federal control number are required. CRNAs can only administer drugs during surgery when the physician, who is physically present in the institution, clinic, or other setting.

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

■ Legal Authority
Advanced Practice Nurses (APNs) include Nurse Practitioners (NPs), Certified Nurse Specialists (CNSs), Certified Nurse Midwives (CNMs), and Certified Registered Nurse Anesthetists (CRNAs).

If the APN’s scope of practice does not include independent acts of diagnosis or prescribing, practice authority is governed solely by the BON. Otherwise, the APN applies to the JPC (composed of APNs, MDs, a pharmacist, and one public member). The JPC is statutorily empowered, with Board of Medical Practice (BOMP) approval, to grant independent practice and/or prescriptive authority to nurses who qualify. APN applicants must have a master’s degree or post-baccalaureate 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, management of problems within the clinical specialty, advanced pathophysiology, and advanced pharmacology. If the APN graduated from an approved program more than 2 years before application, the APN must document the equivalent of at least 30 hours continuing education in pharmacology and other areas. The collaborative agreement is a written document that outlines the process (for consultation, referral, and/or hospitalization 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, dentist, podiatrist, or licensed healthcare delivery system.” If the agreement is with a licensed healthcare delivery system, the document must clarify that the system will supply appropriate medical backup for purposes of consultation and referral. Requirements for physician supervision, chart review, or on-site physician visits do not exist.

■ Reimbursement
Health insurers, health service corporations, and HMOs shall not deny benefits for eligible services when rendered by an APN acting within his or her scope of practice. APNs may be listed on provider panels; some providers recognize APNs on managed care provider panels. CNMs have legislative authority under the Board of Health for third-party reimbursement. FPNs and PNPn also receive Medicaid reimbursement on 100% of physician payment.

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

■ Legal Authority
ARNPs are certified by the BON and include NPs, CNMs, and CRNAs. Initial ARNP certification requires 500 supervised clinical hours in the educational program. An ARNP shall only perform medical acts of diagnosis, treatment, and operation pursuant to a protocol between the ARNP and a physician, DO, or DDS. The degree and method of supervision, determined by the ARNP and physician, DO, or DDS, shall be specifically identified in written protocols and shall be appropriate for prudent healthcare providers under similar circumstances. The 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 in private practice must find a physician willing to sponsor the ARNP’s protocols. ARNPs must file protocols with the BON yearly, and the physicians working with the ARNP must send the statement required in the medical practice act to the BOM. ARNP applicants must have a master’s degree to qualify for initial certification. ARNPs, within the framework of established protocols, may order diagnostic tests and physical and occupational therapy. In compliance with the Mandatory Practitioner Profiling statute, all healthcare providers are required to submit information on criminal history, financial responsibility, liability actions, and fingerprinting. ARNPs must show proof of malpractice insurance or provide a reason for exemption.

■ Reimbursement
ARNPs receive Medicaid, Medicare, CHAMPUS, and third-party reimbursement. Medicaid reimburses ARNPs at 80% of physician payment; Medicaid only pays 100% if an on-site physician countersigns the chart within 24 hours. Managed care companies are prohibited from discriminating against the reimbursement of ARNPs if based on licensure. Private insurers must reimburse NM services if the policy includes pregnancy care.

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

■ Legal Authority
Advanced Practice Nurses (APNs) include Nurse Practitioners (NPs), Certified Nurse Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), and Clinical Nurse Specialists (CNSs). APN practice is defined in the 1985 Health Occupations Revision Act (HORA). Current law, as described in the 1995 HORA amendments, authorizes APNs to practice without a physician collaborative agreement or protocols. The APN scope of practice (SOP) is without limitations and regulated by the BON. APNs may apply for hospital privileges.

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

The BON/BOM joint committee allows Rx privileges for ARNPs; however, controlled substances are excluded. ARNPs prescribe under their protocol, which broadly lists the medical SOP and generic categories from which the ARNP can prescribe. ARNPs use their own Rx pad (containing name and license number); the pharmacist is required to put the prescriber’s name on the drug label. As of July 1, 2003, a new law required written prescriptions to be legibly printed or typed and signed by the prescribing practitioner on the day issued. ARNPs who dispense (distribute medication for reimbursement) must apply for dispensing privileges. Giving free samples is allowed and not considered dispensing.

Prescriptive Authority

A process exists that permits RNs (including APRNs) to administer, order, or dispense drugs under delegated medical authority, either as prescribed by a physician or as authorized by protocol. BON regulations governing protocols used by RNs require that the RN document preparation and performance specific to each medical act. Ordering is not construed to be prescribing nor the issuance of a written prescription. “Medication orders” may be called into a pharmacy. There are continuing legislative efforts to amend the current limitation and allow such orders to be transmitted in writing.

Reimbursement

Current law provides direct reimbursement to all APRNs. Several insurance companies are in the process of credentialing APRNs for their provider panels. Some APRNs are listed on managed-care panels and are directly reimbursed for services. The reimbursement rate ranges from 85% to 100%. NPs and CNSs are also reimbursed through CHAMPUS. Medicaid expanded the types of APRNs they reimburse to include Psychiatric CNSs and additional specialties of NPs (only PNPs and FNPWs were reimbursed before). Medicaid reimburses at 75% of physician payment. Hawaii Health QUEST, a Medicaid waiver program, defines PNPs, FNPWs, and CNMs as PCPs. However, QUEST, unlike Medicaid, does not require the QUEST healthcare plans to include APNs as PCPs on their provider panels.

Prescriptive Authority

Under a 2002 law, prescriptive authority for APRNs is regulated by the BON. During the 2003 legislative session, a sweeping Administration Bill reversed the 2002 bill. The Governor’s office has reported that in their opinion the reversal of the 2002 bill (related to the BON jurisdiction) occurred in error and will be rectified. In the meantime, the BON is still regulating APRNs’ prescriptive authority. The BOME submits an annual report of permissible formulations to the BON. The Department of Commerce and Consumer Affairs establishes a joint formulary advisory committee (composed of two APRNs, two MDs, three pharmacists, one medical school appointee, and one nursing school appointee). The joint formulary advisory committee makes formulary recommendations to the BOME. The advisory formulary committee has forwarded recommendations to allow APRNs to prescribe controlled substances under physician supervision. The BOME is currently considering these recommendations. APRN prescriptive authority is not supervised; however, APRNs must document with the Department of Commerce and Consumer Affairs that they have a collegial working relationship with an MD working in the same “institution” and specialty area. APRNs prescribe from an exclusionary formulary that excludes controlled substances. To prescribe from the formulary, APRNs must have a master’s degree in nursing or nursing science, 30 hours of advanced pharmacology, 1,000 hours of clinical practice, and national certification. Master’s and nonmaster’s-prepared APRNs can prescribe controlled substances under protocols when the physician agrees. APRNs with prescriptive authority may receive pharmaceutical samples.

Reimbursement

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

Prescriptive and dispensing authority is granted to APNPs who have completed 30 contact hours of pharmacology-specific formal instruction beyond basic RN education. Authorized APNPs may prescribe and dispense legend and Schedules II, III, IV, and V controlled substances appropriate to their defined scope of practice. Some dispensing restrictions apply to Schedule II substances. Authorized APNPs have their own DEA numbers and prescribe independently.

Illinois

http://www.idpr.com

Legal Authority

Certified Nurse Practitioners (CNPs), Clinical Nurse Specialists (CNSs), Certified Nurse Midwives (CNMs), and Certified Registered Nurse Anesthetists (CRNAs) are title protected and statutorily recognized as Advanced Practice Nurses (APNs). APNs may not use the title “Dr.” in a clinical setting. All new applicants must have a graduate degree in their APN specialty; however, recent legislation was passed allowing RNs who do not have a master’s degree but successfully completed a nurse anesthesia program prior to January 1, 1999, to obtain an APN license if they apply on or before December 31, 2006 and meet other licensure requirements. APN practice is regulated by the Department of Professional Regulation’s APN Board (composed of four APNs, three physicians who must be in a collaborative practice with an APN, and two public members). CNPs, CNSs, and CNMs must have a written collaborative agreement with a physician that describes the working relationship between the APN and the physician and authorizes the categories of care, treatment, or procedures to be performed by the APN. Medical direction is adequate if the APN and physician jointly develop the guidelines and periodically review them. The agreement need not describe the exact steps for a specific condition, disease, or symptom but must specify which authorized procedures require a physician’s presence. The physician’s presence is not required at the site where services are rendered; however, telecommunication methods for consultation must be established, and the physician is expected to visit the site at least once a month. The APN shall provide services that the collaborating physician generally provides. Ratios are not specified; however, the Medical Practice Act prohibits a physician from entering into an “excessive number” of written collaborative agreements with licensed APNPs, resulting in an inability to adequately collaborate and provide medical direction. The School Code and Transportation Code allow APNPs to sign physical examination forms and require the Department of Human Services to include the Illinois Society for Advanced Practice Nursing in developing and distributing a health education brochure.

Reimbursement

The Illinois Department of Public Aid provides direct reimbursement at 70% of physician rates to certified FNPs and FNP-CCs who enroll independently as Medicaid providers. FNP-CCs may alternately choose to bill under a physician and receive 100% reimbursement. Statutory prohibition for third-party reimbursement to APNs does not exist. APNs receive direct or indirect reimbursement from third-party payers in some cases.

Prescriptive Authority

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

Indiana

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

Legal Authority

Indiana’s Nurse Practice Act (NPA) defines Advanced Practice Nurses (APNPs) as NPs, CNMs, or CNSs. The BON does not issue separate licenses to NPs or CNSs. CNMs must apply for “limited licensure” to practice. APNPs without Rx authority may function in their advanced practice with their RN license however, a Written Collaborative Practice Agreement (WCPA) is necessary if the APN seeks Rx authority. Current law specifies that between 1%-10% of all collaborative practice agreements shall be audited. NPs can independently sign for Federal Trucking Physical Examinations, however, they are not legally authorized to independently sign for school physical examinations. The NPA defines CRNAs separate from APNPs.

Reimbursement

Indiana is considered an “any willing provider” state, backed by current law. APNPs 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, with the approval of the BOM, to permit Rx 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 an Rx authority identification number; the authority limits an APN’s prescriptive 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. 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. A 2003 BON Rule concerning Rx authority for APNs waives a pharmacology requirement for certain APNs transferring into the state (as long as they meet CE requirements) and requires renewal applicants to submit proof of 30 hours or more of CE during the past 2 years along with a current signed and dated collaborative practice agreement. CRNAs are not required to obtain Rx authority to administer anesthesia.

Iowa

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

Legal Authority

Advanced practice administrative rules are in the administrative code. ARNPs (NPs, CRNAs, CNMs, and CNSs) are registered by the BON in addition to their RN license. ARNPs may practice independently. Collaborative practice agreements are not required. In addition to independent functions, an ARNP may perform selected medically delegated functions when a collaborative practice agreement exists. The Hospital Fairness Bill allowed ARNPs to obtain hospital clinical privileges. A 2002 Senate bill removed barriers to NP care...
provided in birth centers; CNMs now follow the practice act for care provision in any site.

Reimbursement
Payment of necessary medical or surgical care and treatment is provided to an ARNP if the policy or contract would pay for the care and treatment when provided by a physician or DO. Managed care organizations are not mandated to offer ARNP coverage unless there is a contract or other agreement to provide the service. Under 2003 legislation, 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 independent Rx authority. ARNPs may prescribe, deliver, distribute, or dispense uncontrolled and controlled drugs, devices, and medical gasses. Registration with the federal DEA and the Iowa BOP extends this authority to controlled substances. ARNPs write prescriptions using their own Rx pads.

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

Prescriptive Authority
ARNPs may prescribe non-scheduled legend drugs pursuant to a collaborative practice agreement (CPA) that defines ARNP scope of prescribing authority and is signed by the ARNP and physician. CRNAs do not need CPAs to deliver anesthesia care. The BON has defined “collaboration” and “CPA,” and specific information that must be contained in the CPA (e.g., ARNP and collaborating physician’s name, practice address, and area of practice). The ARNP alone signs his/her name to the Rx pad when prescribing. ARNPs must complete 5 contact hours in pharmacology (every 2 years for relicensure) as part of their CE requirement. ARNPs may receive drug samples (non-controlled legend medications only) and may dispense drug samples to patients at no charge. Dispensing is applicable to ARNPs working in health departments: ARNPs may dispense with a written agreement with a local pharmacist.

Reimbursement
A 1990 statutory requirement reimburses all ARNPs for covered services in health plans. Medicaid has expanded payment to include all covered services at 80% of physician payments (except for practitioners performing early periodic screening diagnosis and treatment, who receive 100%). CRNAs receive 85% of physician payments. Some insurance companies are paying 85% of physician payments to ARNPs.

Prescriptive Authority
A pharmacy law permits ARNPs, except CRNAs, to prescribe medications pursuant to protocols jointly adopted by the ARNP and “the responsible physician.” Each written protocol must (1) specify the drug class the ARNP is permitted to prescribe for each classification of disease or injury, (2) be maintained in a notebook or book of published protocols, and (3) contain the ARNP’s and physician’s annual signature. The prescription order must be signed by the ARNP and include the name of the physician and ARNP. ARNPs are eligible to apply for DEA numbers and permitted to receive drug samples, if the drug is within their protocol.
provider identification numbers to CNPs and CNMs; and allows managed care enrollees to designate CNPs as their PCP. However, managed care organizations are not required to credential any physician or CNP if their “access standards” have been met. Reimbursement under indemnity plans is mandated for master’s-prepared, certified psychiatric/mental health CNSs; no other third-party reimbursement for APRNs is required by law. Some insurance carriers, however, reimburse independent CNPs. Medicaid reimburses in full, on a fee-for-service basis, for services provided by CNPs, CPNPs, and CNMs.

■ Prescriptive Authority

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

■ Reimbursement

All nurses are entitled to private third-party and Medicaid reimbursement for services if they are practicing within their legal scope of practice (SOP). All Medicaid recipients have been assigned to a managed care organization; CRNPs (with the exception of neonatal and acute care) and CRNMs have been designated as primary care providers (PCPs) and may apply to be placed on a provider panel. Medicaid reimburses at 100% of physician payment. Legislation allows due process for APNs listed on managed care panels; APNs are not to be arbitrarily denied. Legislation passed in 2003 requires an HMO to permit an enrollee to select a certified NP as the enrollee’s PCP if (1) the NP provides services at the same location as the NP’s collaborating MD and (2) the collaborating MD provides the continuous medical management required. The law does not require that an HMO include NPs on the HMO panel as PCPs. The state NP association signed an agreement letter with the state medical society that neither will bring this issue back to the legislature for 5 years.

■ Prescriptive Authority

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

Maine

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

■ Legal Authority

Advanced Practice Registered Nurse (APRN) regulation is under the BON. APRNs include CNMs, CNPs, CNSSs, and CRNAs approved by the BON. The APRN scope of practice includes national standards of the national certifying body and “consultation with or referral to medical and other healthcare providers when required by client healthcare needs. A CNP who qualifies as an APRN must practice for at least 24 months under the supervision of a licensed physician or must be employed by a clinic or hospital that has a medical director who is a licensed physician. The CNP must submit written evidence to the BON upon completion of the required clinical experience.” After this 24-month period, the CNP can practice independently. CNSSs practice independently. CRNAs are responsible and accountable to a physician or dentist. CNPs and certified psychiatric CNSs may sign documents for emergency involuntary commitment through emergency departments. There is no statutory requirement promoting or inhibiting the inclusion of APRNs on hospital medical staffs. Workers’ compensation forms recognize CNPs and allow issuance of license plates and cards for the physically disabled.

■ Reimbursement

The 1995 Act to Increase Access to Primary Health Care Services (HP617) requires reimbursement under an indemnity or managed care plan for patient visits to an NP or CNM when referred from a PCP; requires insurers to assign separate

Maryland

http://www.mbon.org

■ Legal Authority

Advanced Practice Nurses (APNs) include Nurse Practitioners (NPs), Certified Registered Nurse Anesthetists (CRNAs), Certified Registered Nurse Midwives (CRNMs), and APRNs/PMHNs (PMH; psychiatric mental health). NPs are certified to practice through the BON; requirements include passing a national certification examination and submitting a written agreement with a collaborating physician (the agreement is approved by an equally represented physician and NP joint committee). Once the agreement is approved, NPs may perform the functions of the agreement independently. CRNMs are certified to practice through the BON; requirements include passing a national certification examination and submitting a written agreement with a backup physician. CRNAs are certified to practice through the BON; requirements include passing a national certification examination and submitting a collaborative agreement with an anesthesiologist, physician, or dentist. APRNs/PMHNs are certified to practice through the BON; requirements include master’s degree or higher and national certification as a clinical specialist (CS) in psychiatric/mental health nursing. APRNs/PMHNs practice independently, make mental health diagnoses, and provide psychotherapy.

Massachusetts

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

■ Legal Authority

Registered Nurses who apply for BON authorization in advanced nursing practice (Nurse Practitioners (NPs), Nurse Anesthetists (NA), psychiatric Clinical Nurse Specialists (CNSSs), and Certified Nurse Midwives (CNMs) must have satisfactory completion of a formal education program, which has as its objective the preparation of nurses to perform as an NP, CNS, NM, or NA. Advanced practice RR & governing the ordering of tests, therapeutics, and prescribing are promulgated by the BON in conjunction with the BOM. All other areas of scope of practice are exclusively under the BON. All Advanced Practice Nurses (APNs) shall practice in accordance with written guidelines developed in collaboration with the nurse and physician. In all cases, the written guidelines shall “designate a

www.tnpj.com

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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. Credentialing for hospital privileges varies according to hospital policies.

**Reimbursement**

Psychiatric CNs, CNMs, CRNAs, and NPs are reimbursed according to state law. This law only includes indemnity plans, not HMOs and other managed care arrangements. BC/BS credentials NPs in private practice settings to receive individual NP provider numbers. An HMO protection bill allows “other providers” to be listed on panels; however, the law does not specifically address APNs or require them to be listed as providers. FNP, PNP, and APNs are reimbursed at 100% of physician payment for Medicaid unless the NP is employed by the hospital in a hospital-based practice.

**Prescriptive Authority**

NPs, CNMs, and psychiatric CNSs have prescriptive authority for Schedules II–V controlled substances. Authorized APNs must apply to the state Department of Public Health for a state DEA number; they then apply for a federal DEA number. Authorized APNs have (1) prescribing guidelines mutually developed and agreed on by the nurse, employer, and supervising physician; guidelines need not be submitted to the BON unless requested (the guidelines pertaining to prescriptive practice shall include a defined mechanism to monitor prescribing practices, including review with a supervising physician every 3 months); and (2) proof of 24 hours of pharmacology content. The prescription pad includes the name of supervising physician; the authorized APN signs the prescription.

**Reimbursement**

Medicaid directly reimburses all certified NPs at 100% of the reimbursement rate. BC/BS directly reimburses all NPs, CNMs, and CRNAs.

**Prescriptive Authority**

Under the Michigan Public Health Code, a prescriber is defined as a licensed health professional acting under the delegation and supervision of and using, recording, or otherwise indicating the name of the delegating physician. NPs, CRNAs, and CNMs may prescribe noncontrolled substances as a delegated act of a physician. There is no requirement for a physician countersignature. Under BOM administrative rules, a physician may delegate the prescription of a controlled substance 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 can also be delegated if the physician and NP or CNM are practicing within a defined health facility (freestanding surgical outpatient facility, hospital, or hospice) and if, on discharge, the prescription does not exceed a 7-day period. A supervising physician may delegate in writing the ordering, receipt, and dispensing of complimentary starter dose drugs other than controlled substances.

**Mississippi**

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

**Legal Authority**

NPs, CRNAs, and CNMs are certified by the BON. The R&R are jointly promulgated by the BON and implemented by the BON. To become certified, the RN must successfully complete an appropriate NP program, be nationally certified as an NP, and submit practice documentation of a collaborative, consultative relationship with a physician whose practice is compatible with the NP. NPs must practice according to a BON-approved protocol agreed on by the NP and physician. CRNAs may also collaborate/consult with licensed dentists. 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&R. BON R&R provide title protection for CNSs. NPs can sign for disability verification, disability license plates, testing of minors for sexually transmitted infections without parental consent, and proof of immunization for Medicaid. NPs can perform the assessment and attest to the health of a child for adoption. Before 1995, the BOM ruled that if an NP treats patients in a “freestanding clinic” (more than 15 miles from the supervising physician), the physician must obtain BOM approval to collaborate with the NP. Legislation of 1995 provides that any action taken to prohibit NPs from practicing fully within their SOP is prohibited, and that “any R&R that impact the practice of NPs shall hereafter be jointly promulgated by the BON and BOM.”

**Reimbursement**

Insurance law specifies that whenever 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 CNP. Medicaid reimbursement is available at 90% of physician payment.
Prescriptive Authority

NPs have Rx authority based on the standards and guidelines of the NP’s national certification organization and a BON-approved protocol that has been mutually agreed upon 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 non-controlled substances for which the NP has Rx authority. Controlled substances (II-V) may be prescribed pursuant to additional BON R&R; a DEA number, completion of a BON-approved educational program, and submission approval of a BON-controlled substance Rx authority protocol are required. CNMs and CRNAs may order controlled substances within a licensed healthcare facility using BON-approved protocol or practice guidelines.

Missouri

http://www.ecodev.state.mo.us/pr/nursing

Legal Authority

Recent legislation authorized a title change from Advanced Practice Nurse (APN) to Advanced Practice Registered Nurse (APRN). Statutory definition of APRN in the NPA includes NPs, CNSs, CNMs, and CRNAs. Pursuant to the BON’s application process, a “Document of Recognition” may be granted by the BON if the APRN rule requirements are met. Individuals are recognized by their specific clinical nursing specialty area as a CNS, NP, NM, or RNA, which delineates their title and scope of practice (SOP) as APRNs. When practicing outside their recognized clinical nursing specialty, individuals must practice and title as RNs only. Continuing recognition as APNs is accomplished through ongoing compliance with APN rule requirements. Additional legislation permits collaborative practice arrangements between RNs recognized as APNs and physicians using written agreements, written protocols, or written standing orders. Joint BON and Board of Healing Arts rulemaking activity, with BOP input, culminated in a Collaborative Practice (CP) rule. Three focus areas in the CP rule are (1) geographic areas to be covered, (2) methods of treatment that may be covered by CP arrangements, and (3) requirements for review of services provided pursuant to a CP arrangement. A written CP arrangement with a physician is not needed when the APN is performing nursing acts consistent with the APRN’s skill, training, education, and competence. A CP arrangement may be indicated to perform physician-delegated medical acts within the mutual SOP of the physician and APRN and consistent with the APRN’s skill, training, education, and competence. In the 2003 legislative session, an Anesthesiologist Assistant bill was passed that exempts CRNAs from the collaborative practice requirements and allows CRNAs to practice under the direction of the surgeon or anesthesiologist.

Reimbursement

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

Prescriptive Authority

BON-recognized APRNs may be delegated administering, dispensing, prescribing, or other medical methods of treatment authorities by a physician pursuant to a written CP arrangement. Delivery of such APRN healthcare services shall be within the APRN’s advanced clinical nursing specialty area and a mutual SOP with the physician, and be consistent with the individual’s skill, training, education, and competence. APRNs may receive/dispense samples within their Rx authority. Delegated Rx authority does not include controlled substances; therefore, a DEA number is not available. In certain instances, a state BNDD number is required.

Prescriptive Authority

APRNs who desire Rx authority apply to the Pre- scriptive Authority Committee, consisting of BON members. CNSs (except psychiatric specialty) are not eligible for Rx authority. APRNs with Rx authority can prescribe all medications, including Schedules II-V controlled substances, using their own DEA number, and are permitted to receive and dispense drug samples. Author- ity 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 Rx authority and includes 15 charts or 5% of all APRN charts, reviewed quarterly by an APRN or physician in the same specialty. New APRN applicants must complete 15 hours of CE pharmacology (in addition to their master’s degree program) before application. CE is required for renewal every 2 years.

Nebraska

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

Legal Authority

Advanced Practice Nurses are licensed as Advanced Practice Registered Nurses (APRNs) by the BON Board, or certified as CNMs or CNMs by the BON and BOM. The Board of APRNs consists of five APRNs, five MDs, three consumers, and one pharmacist. The CNS is not a legally expanded role, but there is title protection in the statute. APRN scope is statute-defined and includes illness prevention, diagnosis, treatment, and management of common health problems and chronic conditions. APRNs must maintain liability insurance ($200,000 per incident and $800,000 aggregate per year) and maintain an integrated practice agreement (IPA) with a collaborating physician. APRNs and physicians shall practice collaboratively and have joint responsibility for patient care, based on the scope of practice of each practitioner. The IPA specifies, “the collaborating physician shall be responsible for supervision through ready availability for consultation and direction of the activities of the APRN.” If, after diligent effort, an APRN is unable to obtain an IPA with a physician, the APRN Board may waive the requirement for an IPA if the APRN has demonstrated proper course work, holds a master’s degree or higher in nursing, has completed 2,000 hours under the supervision of a physician, and will practice in a geographic area where there is a short-
age of healthcare services. APRNs without a master’s or doctoral degree, and/or at least 2,000 hours of physician-supervised practice must also have jointly approved protocols. APRNs licensed after 1996 must have a master’s or doctoral degree to practice, except for women’s health and neonatal. CNMs must practice with consultation, collaboration, and the consent of a physician. CNMs must have a practice agreement jointly approved by the BON and BOM that delineates delegated medical duties; CNMs function under protocols.

### Reimbursement

State legislation mandating third-party reimbursement for APRNs does not exist; consequently, some APRNs have been refused recognition as a provider. Medicaid reimburses ARNPs at 100% of physician payment.

### Prescriptive Authority

Rx authority for APRNs is in the ARNP statute, defining the APRN scope of practice as “prescribing therapeutic measures and medications” and “dispensing incident to practice only sample medications.” Schedule II is limited to 72 hours and pain control only. CRNAs prescribe within their specialty practice; authority is implied in the statute. Qualified CRNAs and APRNs receive DEA numbers. CNMs may not obtain DEA numbers, as their authority to prescribe is dependent, based on the practice agreement.

### Nevada

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

#### Legal Authority

Advanced Practice Nurse (APN) is a protected title recognized by the BON, including NPs, CNMs, and nurse psychotherapists with a master’s degree. The BON may grant a certificate of recognition as an APN to appropriately qualified RNs. The BON-recognized APN may “perform designated acts of medical diagnosis, prescribe therapeutic or corrective measures, and prescribe controlled substances, poisons, dangerous drugs, and devices.” An applicant for an APN certificate of recognition must have completed a BON-approved program and present evidence to the BON of continuous advanced practice of 400 hours per year in 3 of the 5 years prior to the application or present evidence that the applicant will complete 1,000 hours of practice (without Rx writing) under the supervision of a physician or certified APN. Applicants completing an APN program after 6/05 must be master’s prepared. Applicants must present a signed letter of agreement with a collaborating physician (licensed in Nevada) to the BON. The APN must keep written protocols at every job site, together with a collaborative agreement signed by a physician. Recent regulation by the BOME changed “supervision of APNs” to “collaboration of APNs.” The BOME regulation, applicable to physicians, includes a provision that makes the physician apply for approval status and limits the number of APNs with whom any one physician can collaborate. The BON audits 5% of APN practices each year. The BON & R&R certify CNMs who meet educational requirements as APNs. CRNAs and CNSs who function independently but may not prescribe. CRNAs are not considered APNs and do not have a collaborative practice agreement. CRNAs must have a BSN; after 6/05, they must have a master’s degree.

#### Prescriptive Authority

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

### New Jersey

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

#### Legal Authority

NPs, Nurse Midwives, Nurse Anesthetists, and Psychiatric Mental Health Clinical Specialists are licensed by the BON as Advanced Registered Nurse Practitioners (ARNPs). ARNP applicants must provide (1) an official transcript of an approved educational program (including more than 225 hours of theoretical nursing content, more than 480 hours of clinical nursing practice with a precepted experience, and a formal pharmacology course or documentation from the program director that pharmacological interventions have been integrated into the curriculum); (2) national certification in the requested category; and (3) 30 contact hours of CE in a specialty area within 2 years prior to application. ARNPs do not require physician collaboration or supervision. ARNPs and other licensed nurses may delegate patient care tasks (within their scope of practice) to licensed and unlicensed personnel, such as EMTs, PAs, medical assistants, and technicians. Psychiatric Mental Health NPs employed by the Department of Corrections are indemnified and defended under the same conditions as psychiatrists. Occupational therapists can accept referrals from ARNPs.

### Reimbursement

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

### Prescriptive Authority

BON-licensed ARNPs have plenary authority to prescribe controlled and noncontrolled drugs from the official exclusionary formulary determined by the Joint Health Council whose membership consists of three ARNPs appointed from the BON, three physicians appointed by the BOM who work with ARNPs, and three pharmacists appointed by the BOP. ARNPs are assigned a DEA number on request and after licensure as an ARNP. ARNPs also have dispensing authority.

### New Hampshire

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

#### Legal Authority

NPs, Nurse Midwives, Nurse Anesthetists, and Psychiatric Mental Health Clinical Specialists are licensed by the BON as Advanced Registered Nurse Practitioners (ARNPs). ARNP applicants must provide (1) an official transcript of an approved educational program (including more than 225 hours of theoretical nursing content, more than 480 hours of clinical nursing practice with a precepted experience, and a formal pharmacology course or documentation from the program director that pharmacological interventions have been integrated into the curriculum); (2) national certification in the requested category; and (3) 30 contact hours of CE in a specialty area within 2 years prior to application. ARNPs do not require physician collaboration or supervision. ARNPs and other licensed nurses may delegate patient care tasks (within their scope of practice) to licensed and unlicensed personnel, such as EMTs, PAs, medical assistants, and technicians. Psychiatric Mental Health NPs employed by the Department of Corrections are indemnified and defended under the same conditions as psychiatrists. Occupational therapists can accept referrals from ARNPs.
Reimbursement
Private health plans, including Medicaid-managed care plans, are permitted to credential APNs as PCPs, but are not required to recognize or reimburse them. Five HMO/insurers now directly credential and reimburse APNs in New Jersey. Medicaid fee-for-service reimburses APNs at approximately 85% of the physician rate, but the rate may vary according to procedure and setting. BC/BS must reimburse APNs directly if the reimbursed service can be performed within the APN’s SOP and the APN is not an employee of a physician or an institution. The state health benefits plan covering all public employees directly pays some APNs.

Prescriptive Authority
APNs credentialed by the BON are authorized to prescribe or order all noncontrolled substances and devices. Recent changes in law now permit APNs to prescribe controlled substances without restrictions in all clinical settings. APNs must apply for both a state controlled dangerous substance (CDS) number and a federal DEA number. APNs prescribe medications and devices in accordance with a joint protocol, which has been established by the APN and the collaborating physician. The joint protocol is required for prescribing purposes only and is not a collaborative agreement for general practice. APNs can receive and dispense drug samples. Cosignatures are not required for APN documentation, order, or prescriptions.

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

Legal Authority
The NPA defines Certified Nurse Practitioner (CNP) as a primary care provider who can practice independently without physician supervision or collaboration requirements. BON-approved CNPs receive a CNP designation on their RN license; there is no certification designation of the specialty. The CNP must have completed a graduate program for the education and preparation of NPs. 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 CS. CNSs must be master’s prepared and certified by a national certifying nursing organization. CNSs “make independen 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, but CNPs continue to meet resistance in being listed as PCPs. FPNs and PNP’s receive Medicaid reimbursement at 85% of physician payment. All three of the managed care groups contracted to provide Medicaid coverage have contracts with NPs.

Prescriptive Authority
NPs who have fulfilled the requirements for Rx authority may prescribe independently, 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 NP must maintain a formulary and submit a copy to the BON. CNSs must have graduate-level pharmacology, pathophysiology, a physical assessment course, and prescribe in collaboration with a physician, NP, 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 Rx authority requirements may collaborate independently, and prescribe and administer therapeutics, including dangerous drugs and controlled substances within emergency procedures, perioperative care, or perinatal care environments. CNPs and CNSs with Rx authority may divide dangerous drugs and Schedules II–V controlled substances that have been prepared, packaged, or prepackaged by a pharmacist or pharmaceutical company.

New York
http://www.nysed.gov/nurse.htm

Legal Authority
Nurse practitioners are licensed as RNs and certified by the State Education Department as NPs. NPs are considered independent practitioners and are authorized to diagnose, treat, and prescribe in collaboration with a physician in accordance with a written practice agreement and written practice protocols. 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. Cosignatures are not required. NPs may: (1) prescribe home health aid and personal care services, legally function; (2) function as school district medical inspectors; (3) certify that cosmetology and nail applicants are free from disease; and (4) sign for physical examinations for bus drivers. A 2003 law amended the education code stating that respiratory therapy services may be Rx by an NP, and recent legislation amended the education code, giving NPs authority to certify health status for students in public schools. NPs have recently been authorized as practitioners who can perform laboratory tests or procedures, personally or through his or her employees, solely as an adjunct to the treatment of his or her own patients. Midwives are separately licensed to manage normal pregnancies, childbirth and postpartum care, newborn evaluations, and primary preventive reproductive care and prescribe in collaboration (with practice agreements and protocols) with a physician. Although certified midwives may continue to use the title “nurse-midwife,” individuals do not have to be licensed as a nurse to be licensed as a “midwife.”

Reimbursement
NPs of all specialties may register as Medicaid providers and be reimbursed at 100% of the physician rate. Nurses continue to be qualified providers and NPs are specifically mentioned as qualified primary care gatekeepers. A law regulates the practice of HMOs: Provisions are provider-neutral and apply equally to physician and nonphysician providers. Although there is no guarantee that APNs will have a role in managed care delivery, their rights are assured. The law also prohibits “gagging” healthcare providers, establishes due process for termination of provider contracts, allows for access to specialty providers, includes continuity of care provisions for ongoing care with providers outside of the plan, and requires the commissioner of health to determine that there are sufficient providers to meet the covered patients’ needs. ‘Willing Provider’ legislation has been proposed; the public health law would specify “No HMO shall discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing, capable, and can meet the terms and conditions for participation.”

Prescriptive Authority
The law authorized and the state attorney general endorsed Rx of drugs (Schedules II–V), devices, and immunizing agents without restriction. The DEA has granted individual numbers to NPs since the attorney general interpretation. NPs may order drugs, devices, immunizing agents, tests, and procedures in accordance with the practice agreement and practice pro-
North Carolina

http://www.ncbon.org

Legal Authority
Nurse Practitioners (NPs) apply to a joint subcommittee of the BON and North Carolina Medical Board to obtain practice approval. New NPs must have a master’s degree. NPs may own their practice as long as they contract with a physician. NPs must have a collaborative written practice agreement (CPA) with a physician for continuous availability and ongoing supervision, consultation, collaboration, referral, and evaluation. After the first 6 months of NP practice, in which documented face-to-face meetings are required, NPs and MDs may meet by phone or electronically. The CPA also includes the drugs, devices, medical treatments, tests and procedures that may be prescribed, ordered and performed by the NP as well as a plan for emergency services. The supervising physician does not have to be on site. The NP shall be prepared to demonstrate to the BON or BOM the ability to perform medical acts as outlined in the CPA. Certified Registered Nurse Anesthetists (CRNAs) are regulated solely by the BON and do not have prescriptive authority. CNMs have their own separate statute and are regulated by a midwifery joint committee. CNS recognition and SOP is regulated by the BON, but does not include prescriptive authority. CNs 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 receive Medicaid reimbursement at 100% of the physician rate. CHAMPUS also reimburses NPs. Statutory authority for third-party reimbursement for NP’s provides direct reimbursement to NPs for services within their scope that are reimbursable to a non-nurse provider. Legislation in 2001 covers access to medical advice and care by providing continuity of care, referrals to specialists, selection of specialists as PCPs, direct access to healthcare providers, and many other liability and risk management provisions that are beneficial to the consumer. In the section, “No Discrimination in the Selection of Providers,” patients may choose services from a provider list that includes APRNs. The section, “Provider Directory Information” requires that every health benefit plan use a provider network directory that includes all types of participating providers, including APRNs, upon participating providers’ written request.

Prescriptive Authority
NPs and CNMs may prescribe, compound, dispense, and procure any drugs and devices, including controlled substances that are identified in their CPA. NPs may refill legend drugs up to 1 year and may write controlled substance prescriptions for 30 days; NPs may not refill any controlled substances. The collaborative practice agreements must be signed annually by the NP and all supervising physicians for that practice site and be maintained on site. A DEA number must be obtained. NPs with controlled substances in their collaborative practice agreements must obtain a DEA number (in addition to their prescribing number issued at the time of their approval as NPs).

Ohio

http://www.nursing.ohio.gov

Legal Authority
Ohio state law currently recognizes four groups of nurses in advanced practice roles: Certified Nurse Practitioners (CNP), Certified Registered Nurse Anesthetists (CRNA), Certified Nurse Midwives (CNM), and Clinical Nurse Specialists (CNS). On January 17, 2004, a pilot program to define CNPs, CRNAs, CNMs and CNSs as “advanced practice nurses” (APNs) expired pursuant to legislation passed in 1996. Legislation is currently pending to define CNPs, CRNAs, CNM, and CNSs as APNs, however these classes of nurses have title protection. Legal authority to practice requires collaborative arrangements between a backup physician and a CNP, CNM, or CNS. These groups of nurses (except Psych/Mental Health CNSs) must develop a standard care arrangement (practice agreement) with the collaborating physician. CRNAs are required to practice with a supervising physician. All new applicants for licensure must have a master’s degree in nursing or a related field that qualifies the individual to sit for the national certifying exam. Certification from a national certifying body is required. CNPs and CNSs were included in 1998 legislation concerning do-not-resuscitate orders.

Reimbursement
Medicaid administration 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. New Medicaid providers must have a master’s degree after January 1, 2003. Managed care organizations vary on empanelment. There are no legislative restrictions for an APN being listed on managed care panels. Workers’ compensation continues to reimburse CNPs, CRNAs, and CNSs.

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

Oklahoma
http://www.lsb.state.ok.us
http://www.youroklahoma.com/nursing

Legal Authority
Advanced Practice Nurses (APNs) are defined as Advanced Registered Nurse Practitioners (ARNPs), Certified Nurse Midwives (CNMs), Clinical Nurse Specialists (CNSs), and Certified Registered Nurse Anesthetists (CRNAs) in the NPA and regulated by the BON. APNs must make a formal program of study approved by the BON and be nationally certified by an appropriate certifying body. The APRN practices within the scope of practice (SOP) as defined by the NPA. The SOP applies to identified specialty categories which further delineate the population served: adult, school nurse, family, geriatric, neonatal, pediatric, women’s health care, and acute care. In 2003, Adult Psychiatric and Mental Health, and Family Psychiatric and Mental Health were added as specialty categories.

Reimbursement
Legislation addressing third-party reimbursement for ARNPs does not exist. After prescriptive authority legislation passed, the state Medicaid managed care HMO added ARNPs as primary care managers in rural areas only. A major insurance company in the state (Oklahoma State and Education Employees Insurance) added ARNPs as providers in 1997. Negotiation continues with other third-party insurers.

Prescriptive Authority
The BON regulates optional prescriptive authority for ARNPs, CNSs, and CNMs. Physician supervision is only required for the prescriptive authority portion of advanced practice. Prescribing parameters include: (1) not be on the exclusionary formulary approved by the Board, (2) must be within the ARNP, CNM, and CNS SOP, (3) include Schedules III-V controlled substances (7-day supply) if state narcotics and DEA registrations are obtained, and (4) include signing to receive drug samples. ARNPs, CNMs, and CNSs must have 45 contact hours or 3 academic hours of pharmacology in the 3 years immediately preceding the initial application for Rx authority and 15 contact hours or 1 academic hour every 2 years for renewal. CRNAs have authority to “order, select, obtain, and administer legend drugs, Schedules II-V controlled substances, devices, and medical gases, when engaged in preanesthetic preparation and evaluation, anesthesia induction maintenance and emergence, and postanesthesia care.” Regulation is by the BON. The CRNA functions under the supervision of a physician, DO, or dentist licensed in Oklahoma and under conditions in which timely on-site consultation by such physician, DO, or dentist is available. CRNAs must have a minimum of 15 CEUs and evidence of professional liability insurance for initial application for Rx authority; 8 CEUs for biennial renewal in advanced pharmacology related to administration of anesthesia within the 2 years immediately preceding the date of initial application and renewal. CRNAs must obtain state narcotics and DEA registrations to order Schedules II-V controlled substances.

Pennsylvania
http://www.dos.state.pa.us/nurse

Legal Authority
Certified Registered Nurse Practitioner (CRNP) regulation is under the sole authority of the BON. A CRNP performs the expanded role in collaboration with a physician. Collaboration is defined as a process in which a CRNP works with one or more physicians to deliver healthcare ser-
Prescriptive Authority

Rhode Island

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

Legal Authority

Advanced Practice Nurses (APNs) include Certified Registered Nurse Practitioners (CRNPs), Certified Registered Nurse Anesthetists (CRNAs), and Psychiatric and Mental Health Clinical Nurse Specialists (PCNSs). The practice of APNs is covered under the NPA. Recent legislation disbanded the Registered Nurse Joint Practice Advisory Committee and formed the Advanced Practice Advisory Committee who meet regularly to assess APN practice to improve patient care and to review applications and complaints. The committee reports to the BON. There are no requirements for physician collaboration to practice as a CRNP, with the exception of prescriptive authority. Certified Nurse Midwives (CNMs) have a separate law and separate R&R that are not under the BON. BON R&R define CNMs.

Reimbursement

Legislation 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 primary care providers. CRNAs receive third-party reimbursement for services under the supervision of anesthesiologists or dentists.

Prescriptive Authority

Rhode Island requires a collaborative practice agreement for prescriptive authority. CRNPs are authorized to apply for Controlled Substance registration for privileges to prescribe legend and Schedules II-V controlled substances (CS). Prescriptive authority registration requires 30 hours of pharmacy CE within 3 years prior to application, Advisory Committee approval, and written collaborative guidelines with a physician. A six-member Formulary Committee recommends what the drug formulary contains. The CRNP and collaborating physician or medical director develop practice guidelines, which determine the drugs that will be prescribed from the formulary; the practice guidelines are kept at the practice site and updated annually. Pharmacists have a list of all CRNPs with Rx privileges. Effective Jan. 1, 2004, PCNSs have the authority to prescribe certain legend medications, CS from Schedule II classified as stimulants and CS 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. To qualify for prescriptive authority, the PCNS must show evidence of 30 hours of education in pharmacology of psychotropic drugs within 3 years of application; to maintain Rx privileges, the PCNS must obtain 30 hours CE in pharmacology of psychotropic drugs every 6 years. 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-V controlled substances if the practitioner has obtained the required state and federal registrations.

South Carolina

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

Legal Authority

In May of 2004, South Carolina’s Governor signed into law revisions of the NPA for Advanced Practice Registered Nurses (APRNs). Changes include defining an “APRN” as a nurse practitioner (NP), certified nurse midwife (CNM) or clinical nurse specialist (CNS). APRNs must hold a masters degree in advanced practice nursing and certification in an advanced practice nursing specialty. The Board of Nursing (BON) maintains statutory and regulatory authority over APRNs. APRNs may perform “delegated medical acts” in addition to nursing acts defined by the BON. “Delegated medical acts” may be performed by APRNs pursuant to an approved written protocol between the nurse and physician, and are defined as “additional acts delegated by the physician that include formulating a medical diagnosis and initiating, continuing, and modifying therapies, including prescribing drug therapy under approved written protocols.” NPs who manage delegated medical aspects of care must have a supervising physician who can be accessed by electronic means, and operate within the “approved written protocols.” Approved written protocols are specific statements developed collaboratively by the physician and the nurse that establish physician delegation for the medical aspects of care, including prescribing medications. The protocols must be reviewed and signed annually. When application is made for more than three NPs to practice under one physician or when the NP is performing delegated medical acts in a practice site greater than 45 miles from the physician, the BON and BOM
will determine if adequate supervision exists. The BON conducts a random survey of the protocols, practitioner, and practice site.

Reimbursement
All NPs may apply for a Medicaid provider number; NPs are paid 80% of the physician payment rate. The state health and human services finance commissioner requires that NPs have current, accurate, and detailed treatment plans.

Prescriptive Authority
APNs have limited prescriptive authority. Prescriptions by NPs are limited to “drugs and devices utilized to treat common, well-defined medical problems within the specialty field of the NP as authorized by the physician and listed in the approved written protocols.” NPs are authorized to prescribe Schedules III-V controlled substances. The BOP has opined that, “The supervising physician is not the prescriber. The NP prescribes independently of the supervising physician, has their own DEA registration, and must have a state and federal ID number.” The BON issues an identification number to the nurse authorized to prescribe. State law requires prescriptions by NPs be signed by the NP, contain the NP’s BON-assigned prescriptive authority number, and the physician’s name and address preprinted on the prescription blank. NPs or CNSs with prescriptive authority may request, receive, and sign for professional samples (except Schedules II-IV controlled substances) and may distribute to patients per approved written protocols.

South Dakota
http://www.state.sd.us/dcr/nursing

Legal Authority
A joint BON and BOM board regulates CNPs and CNMs. CNPs and CNMs must submit a collaborative agreement with a physician licensed in the state before performing the overlapping scope of advanced practice nursing and medical functions. On-site physician collaboration is required one-half day per week. CNSs are regulated by the BON. Physician supervision is not required. Before ordering durable medical equipment or therapeutic devices, CNSs must collaborate with a physician. CRNAs are regulated by the BON. CRNAs 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
CRNAs, CNPs, and CNMs can receive third-party reimbursement. 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. 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. CNSs may be reimbursed under specific plans. Medicaid reimbursement is allowed only if billed through a physician’s practice.

Prescriptive Authority
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, 48-hour supply. Therefore, the amount provided is at the professional discretion of the CNP or CNM and the collaborating physician. CNPs or CNMs who accept controlled substances, either trade packages or samples, must maintain a record of receipt and disposition. CRNAs and CNSs do not have Rx authority. CNSs may order and dispense durable medical equipment and therapeutic devices in collaboration with a physician.

Tennessee
http://www.tnaonline.org

Legal Authority
Tennessee law TCA 63-126 requires Advanced Practice Nurses (APNs) to be certified by the Board of Nursing (BON) to practice and represent themselves as a nurse practitioner (NP), certified nurse midwife (CNM), certified registered nurse anesthetist (CRNA) or clinical nurse specialist (CNS). APNs meeting requirements for prescriptive authority are eligible for a certificate that is designated “with certificate of fitness”. APNs must hold a current RN license in Tennessee or a compact state if home state is a compact state. The BON has sole authority to establish the qualifications, competencies, training, education, and experience required to prescribe. 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 who have a BON-issued certificate to prescribe (requires a master’s or doctorate in nursing; preparation in specialized practitioner skills at the master’s, postmaster’s, doctorate, or postdoctoral level; three academic quarter hours of pharmacology, or its equivalent; and current certification in the appropriate nursing specialty area) may write and sign prescriptions and/or issue legend drugs under protocols in any practice site. This authority includes prescribing Schedules II-V controlled substances. The APN’s script pad must have the preprinted name and address of the supervising physician and of the APN. Legislation in 2003 removed the requirement that the APN must include the name of the physician on the signature line, thus the Rx is deemed to be that of the APN. NPs may receive and issue drug samples.

Texas
http://www.bne.state.tx.us
http://www.cnaptexas.org
http://www.texasnurses.org

Legal Authority
Nurses in advanced practice (Nurse Practitioner-
Prescriptive Authority

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

Reimbursement

All APN categories are eligible for direct Medicaid reimbursement at 85% of physician payment rates. Medicaid rules permit APN services provided under jointly developed protocols to be billed as a physician service at 100% of the physician rate. Some programs such as HealthSteps reimburse all providers at the same rate. NPs can be PCPs in the primary care management model for Texas Medicaid managed care. Most APN categories must have a Medicare provider number before they will be granted a Medicaid number. APNs must be master’s degree prepared and nationally certified to perform. APRNs and CNMs may sign for physical examinations required for school bus drivers and cosmetologists. In 2003, H.B. 1095 passed allowing APNs to prescribe controlled substances (CS) Schedules II-V. H.B. 1095 requires hospitals, HMOs, and PPOs to use a standardized application form when credentialing APNs.

Legal Authority

Advanced Practice Registered Nurses (APRNs) in patient-centered ambulatory care practice sites in the hospital or ambulatory care setting; they may not sign for prescriptions to be filled outside the hospital. APRNs, CRNAs, and CNMs receive a DEA number after passing a controlled substance examination and obtaining a state-controlled substance license. APRNs and CNMs may sign for and dispense drug samples.

Reimbursement

All APN categories are eligible for direct Medicaid reimbursement at 85% of physician payment rates. Medicaid rules permit APN services provided under jointly developed protocols to be billed as a physician service at 100% of the physician rate. Some programs such as HealthSteps reimburse all providers at the same rate. NPs can be PCPs in the primary care management model for Texas Medicaid managed care. Most APN categories must have a Medicare provider number before they will be granted a Medicaid number. APNs must be master’s degree prepared and nationally certified to perform. APRNs and CNMs may sign for physical examinations required for school bus drivers and cosmetologists. In 2003, H.B. 1095 passed allowing APNs to prescribe controlled substances (CS) Schedules II-V. H.B. 1095 requires hospitals, HMOs, and PPOs to use a standardized application form when credentialing APNs.

Prescriptive Authority

The 2003 legislation allows physicians to delegate prescriptive authority for CS Schedules II-VI including the following: (1) APNs may only Rx a maximum 30 day supply; (2) the APN must consult with the physician before authorizing a refill; (3) APNs may not Rx CS to a child under 2 years without physician consultation; (4) physician consultation must be noted in the chart. APNs must obtain a prescriptive authorization number from the BNE. To receive the number, the nurse must be authorized to practice as an APN in Texas and meet certain additional educational requirements. To use prescriptive authority, APNs must practice in a qualifying site; a nurse must have, the physician must submit a form to the Texas State BME indicating to whom he/she is delegating authority and in what site. Sites qualifying for prescriptive authority are: (1) sites that meet medically underserved populations, (2) physician alternate practice sites, (3) physician primary care practice sites, and (4) facility-based practices in hospitals or long-term care facilities. The delegating physician must spend some time at each site with the APN, but that time varies from once every 10 business days in a medically underserved population site to the majority of the time in a physician’s primary practice site. The BME has authority to waive any of the requirements based on the recommendations of an advisory committee consisting of five APNs, five physicians, and five PAs. APNs with prescriptive authority may request, receive, possess, and distribute samples of drugs they are authorized to prescribe.

Utah

Reimbursement

The state insurance code has a nondiscrimination code; nothing prohibits reimbursement. Most insurance companies reimburse CNMs, APRNs, and CRNAs. The state health department Medicaid advisory board implemented certified FNP and FNP reimbursement at 100%. CNMs are reimbursed at 65% by Medicare, whereas other APRNs receive reimbursement at 80%.

Legal Authority

Advanced Practice Registered Nurses (APRNs) in patient-centered ambulatory care practice sites in the hospital or ambulatory care setting; they may not sign for prescriptions to be filled outside the hospital. APRNs, CRNAs, and CNMs receive a DEA number after passing a controlled substance examination and obtaining a state-controlled substance license. APRNs and CNMs may sign for and dispense drug samples.

Reimbursement

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

Prescriptive Authority
Prescriptions, including Schedules II-V controlled substances, may be written and signed by the APRN for medications covered in the practice guidelines. A list of BON-endorsed APRNs is made available to the BOP. NPs receive DEA numbers. APRNs have the same privileges dispensing and administering drugs as physicians.

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

Legal Authority
The BON and BOM have statutory authority to regulate licensed nurse practitioners (LNPs), which include Nurse Practitioners, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists. Clinical Specialists are registered solely with the BON. The presidents of the BON and BOM each appoint three board members to the Committee of the Joint Boards of Nursing and Medicine to administer LNP regulations. LNPs must be nationally certified to apply for state authorization and must practice under the medical direction and supervision of a physician. NP practice is based on education and written protocols; the NP may practice only within the scope of practice (SOP) agreement with a supervising physician. “Supervision means that the physician documents are readily available for medical consultation by the LNP or the patient, with the physician maintaining ultimate responsibility for the agreed upon course of treatment and medications prescribed.” Physical therapists may treat on referral of an LNP. LNPs are required to complete at least 40 hours CE in the area of their specialty practice for licensure renewal. LNPs with prescriptive authority must complete an additional 8 hours of CE in pharmacology or pharmacotherapeutics. Recent legislative changes to the NPA now include NPs whenever any law or regulation requires a signature. Certification, stam, verification, affidavit, or endorsement by a physician. Among other things, NPs are now authorized to certify medical necessity of durable medical equipment that is to be reimbursed by Medicaid.

Reimbursement
NPs can independently bill insurers, but are not always paid because they are not mandated providers. 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. FPNs, PNP, and CNMs receive Medicaid reimbursement at 100% of physician payment.

Prescriptive Authority
Authorized LNPs (as designated by the BON and BOM) may prescribe all legend drugs. A Practice Agreement developed between the NP and the supervising physician is submitted to the joint boards; this agreement lists the drug categories the NP will prescribe. Furthermore, NPs may only prescribe legend drugs if “such prescription is authorized by the written agreement between the NP and physician.” NPs acting under a Practice Agreement are authorized to prescribe Schedules III-V Controlled Substances and legend drugs authorized in the practice agreement. The prescription can contain only the NP’s name, but the patient must be informed in writing of the name and address of the supervising physician. Each physician may have a Practice Agreement with four NPs in both for-profit and nonprofit sites. Physicians who supervise NPs require periodic site visits. The joint regulations of the BON and BOM include requirements for continued NP competency (for example, CE testing). The regulations also address ethics, standards of care, patient safety, the use of new pharmaceuticals, and communication with patients. The Joint Commission on Health Care (with full cooperation of nursing, NP, and physician boards and societies) studied the impact of the new prescriptive authority regulations on legal, reimbursement, and safety issues and presented a findings report to the 2004 general assembly. 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 or her patients manufacturer’s samples of controlled substances and devices that he is authorized to prescribe according to his practice setting and a written agreement with a physician.”

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

Legal Authority
Advanced practice is authorized by the Nursing Care Quality Assurance Commission (NCOAC, formerly the BON) for NPs (family, pediatric, adult, geriatric, school, neonatal, psychiatric, women’s health, acute care), CNMs, CRNAs, and CNSs in psychiatric/mental health nursing. ARNP practice is independent. ARNPs assume primary responsibility for continuous and comprehensive management of a broad range of patient care, concerns, and problems. A 2003 law clarifies that ARNPs may make determinations about whether an individual meets the statutory criteria to qualify for special parking privileges. ARNPs can also sign patient death certificates and complete written reports for probate court guardianship proceedings. Though ARNPs had previously cared for injured workers covered under the state’s industrial insurance program, it was not until a new law became effective on July 1, 2004 that ARNPs could sign accident report forms and time loss cards.

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

Prescriptive Authority
ARNPs who qualify may receive Rx authority for Schedule V and legend drugs. ARNPs (except CRNAs) may also obtain Rx authority for Schedules II–IV controlled substances if there is collaboration and a joint practice agreement (JPA) between an ARNP and a physician and endorsement by the DEA. A JPA applies only to prescribing Schedule II–IV CS. The dispensing of Schedules II–IV controlled substances is limited to a maximum 72-hour supply of the prescribed drug. Independent Rx authority entails an initial 30 hours of pharmacotherapeutic education within the area of practice obtained within the 2-year period immediately prior to application. Renewal of Rx authority every two years requires 15 hours of pharmacotherapeutic education within the area of practice.

West Virginia
http://www.wvmbboard.com

Legal Authority
R&R define advanced practice for RNs. Licensed RNs may announce advanced practice (ANP) if they have BON-recognized national certification. All ANPs must have a Masters of Science in Nursing. No special license is issued;

www.tnpj.com
the RN license includes the title granted by the approved national certifying body. APNs include Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse Midwives (CNMs), and Registered Certified Nurse Anesthetists (CRNAs). APRNs hold a master’s degree in nursing or a related health field. After initial prescriptive authority certification, the APNP must submit evidence to the board of an average of 8 CE contact hours per year in clinical pharmacology/therapeutics relevant to the APNP area of practice. DEA numbers are issued to APNPs. The APNP may prescribe Schedules II-V controlled substances and must comply with restrictions regarding prescribing anesthetics and anabolic steroids. Drug samples may be dispensed if the APRN is certified to prescribe prepackaged doses may be dispensed independently if the nearest pharmacy is more than 30 miles away.

**Wyoming**

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

**Legal Authority**

The NPA authorizes the BON to recognize Advanced Practice Nurses (APNs) after demonstrated advanced education or national certification. APNs include Nurse Practitioners (NPs), Certified Nurse Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), and Clinical Nurse Specialists (CNSs). The NPA defines APN as an RN who performs advanced nursing acts and who may perform medical acts, including prescribing or providing prepackaged drugs, except Schedule I drugs. BON R&R specify that the APN must have demonstrated advanced education or national certification. APNs include Nurse Practitioners (NPs), Certified Nurse Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), and Clinical Nurse Specialists (CNSs). The NPA defines APN as an RN who performs advanced nursing acts and who may perform medical acts, including prescribing or providing prepackaged drugs, except Schedule I drugs. BON R&R specify that the APN must have a collaborative plan that describes the APN’s scope of practice, methods of quality assurance, and consultation and referral patterns and strategies for collaboration. According to a 1994 letter of advice from the attorney general, collaboration as it applies to the advanced practitioner of nursing (including the CRNA), does not mean a supervised/dependent form of practice. APNs are specified as providers on worker’s compensation lists and may order physical therapy without a physician cosignature.

**Reimbursement**

All PCPs should receive third-party reimbursement. Medicaid payments to APNs are at 100% of physician payment.

**Prescriptive Authority**

APNs may independently prescribe legend and Schedules II-V controlled substances. APNs must show (1) proof of 30 hours of pharmacotherapeutic education within the last 5 years and who may perform medication acts, including prescribing or providing prepackaged drugs, except Schedule I drugs. BON R&R specify that the APN must have a collaborative plan that describes the APN’s scope of practice, methods of quality assurance, and consultation and referral patterns and strategies for collaboration. According to a 1994 letter of advice from the attorney general, collaboration as it applies to the advanced practitioner of nursing (including the CRNA), does not mean a supervised/dependent form of practice. APNs are specified as providers on worker’s compensation lists and may order physical therapy without a physician cosignature.

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**Wisconsin**

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

**Legal Authority**

Advanced Practice Registered Nurse (APRN) is the protected title for Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse Midwives (CNMs), and Certified Registered Nurse Anesthetists (CRNAs). APRNs function under the Nurse Practice Act with a broad description of nursing practice. The following BON R&R cover the performance of a delegated medical act by an RN: (1) the RN must follow protocols or written or verbal orders; (2) as jointly determined by the RN and physician, the ability to perform the delegation is based on the RN’s education, training, and experience; (3) the RN must consult with the physician when the delegated medical act may harm the patient; and (4) the RN may perform the delegated act under general supervision—the physician does not have to be present in the facility. For APRNs who wish to have independent prescriptive authority (II-V), the BON grants an advanced practice nurse prescriber (APNP) designation after all criteria are met. A BON rule states, “to promote case management, the APNP may order laboratory testing, radiographs, or electrocardiograms appropriate to his or her area of competence as established by his or her education, training, or experience.” APNPs shall work in a collaborative relationship with a physician, defined by law as the “process which involves two or more healthcare professionals working together, in each other’s presence when necessary, each contributing one’s respective area of expertise to provide more comprehensive care than one alone can offer.” The APNP and the physician must document this relationship. Hospital privileges are permissive, not prescriptive; therefore, some hospitals extend full admitting privileges to APRNs, others do not.

**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 NAAACOG. NPs are to charge their usual and customary fee; reimbursement is up to the maximum allowed for physicians billing for the same service. Qualified NPs can be 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 panel.RNs are to charge their usual and customary fee; reimbursement is up to the maximum allowed for physicians billing for the same service. Qualified NPs can be 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 panel. NPs are to charge their usual and customary fee; reimbursement is up to the maximum allowed for physicians billing for the same service. Qualified NPs can be 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 panel.