NURSE PRACTITIONER’S BUSINESS PRACTICE AND LEGAL GUIDE

Sixth Edition

CAROLYN BUPPERT
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Preface
This text contains the answers to many questions asked of me in my 25 years of practice as an attorney. I specialize in legal issues affecting nurse practitioners. The questions came from nurse practitioners, employers of nurse practitioners, hospital and nursing facility executives, student nurse practitioners and their professors, other attorneys, bureaucrats, and legislators conducting hearings about bills that addressed nurse practitioners.

Nurse practitioners frequently ask questions such as these:

- A physician (or hospital or group) wants to hire me to do [fill in a particular healthcare service]. Can I legally do that?
- An insurance company refuses to pay the bill for a patient’s visit with me. What can I do?
- A hospital bought my group’s practice. The hospital is not sure what to do with me. How can I help the administrators understand what nurse practitioners can offer?
- What should be covered in my employment contract?
- Can I incorporate in a business with physicians?
- I have been working in a trauma center for 4 years. Now, I hear that my notes need to be cosigned by a physician. Is that true?
- An Internet-based pharmacist refuses to fill a prescription I wrote because I am not a physician. I have the legal authority to prescribe in my state. What can I do?
- I have been working without a contract. Now, the company wants me to be on call 3 nights a week. Do I have to do it?
- I am writing a paper for my “nurse practitioner role” class on legislative issues affecting nurse practitioners. What are these issues?
- How can I get on a health plan’s provider panel?
- A group wants to pay me a base salary plus a percentage of billings over $250,000. Is this reasonable?
- What does “incident to a physician’s professional services” mean?
- How do I start my own practice?
- I know nothing about how billing is done. Can you tell me how to get reimbursed for my services?

Legislators and bureaucrats frequently ask such questions as these:
- How is a nurse practitioner different from a registered nurse?
- Which states allow nurse practitioners to practice independently?
- How does a nurse practitioner know when to consult a physician?
- Does a physician have to supervise everything a nurse practitioner does?
- In how many states can nurse practitioners write prescriptions?

Employers of nurse practitioners frequently ask such questions as these:

- I want the nurse practitioner to see my hospitalized patients. Can we get reimbursed for that?
- How can we get paid by Medicare for patient visits to the nurse practitioner?
- We want to put nurse practitioners in nursing homes. What can the nurse practitioner do? Admit patients? Perform the yearly visit? Perform illness-related visits? Recertify?
- Who is liable if the nurse practitioner makes a mistake, the nurse practitioner or the physician?

Other attorneys ask such questions as these:

- A nursing home I represent has hired a nurse practitioner to do administrative work and to see
patients. How can we bill for his or her services?

• My clients want to start a network of nurse practitioner practices. What can you tell me about that? Do you know anything about [fill in any state] law on nurse practitioners?

Some of the questioners have become clients, and I have done the necessary legal research to answer their questions and completed the necessary legal documents to carry out their plans. Others will now benefit from the work done for those clients.

Nurse practitioners who read this book will have a solid knowledge base to use, whether it be in developing an employment relationship, undertaking a business venture, giving testimony before a state legislature, composing a letter to an insurance company about an unpaid bill, teaching at a school of nursing, or serving as president of a state or national organization. My hope is that once nurse practitioners have this base of knowledge about the business of health care and the legal foundation on which nurse practitioners function, they can hasten the advancement of their careers.
Chapter 1: What Is a Nurse Practitioner?

Individuals who have never experienced the care of a nurse practitioner (NP)—whether they are physicians, journalists, lawmakers, bureaucrats, lobbyists, or new patients—often request clarification about just who NPs are and what they do.

It is their combination of the skills of both a physician and a nurse that seems to confuse people. Yet it is that combination of skills that makes an NP unique.

Definition of Nurse Practitioner
The term nurse practitioner has been given a variety of definitions.

- According to a state NP organization, “Nurse practitioners are registered professional nurses who are prepared, through advanced graduate education and clinical training, to provide a range of health services, including the diagnosis
and management of common as well as complex medical conditions to individuals of all ages.”

- According to a national NP organization, “NPs are quickly becoming the health partner of choice for millions of Americans. As clinicians that blend clinical expertise in diagnosing and treating health conditions with an added emphasis on disease prevention and health management, NPs bring a comprehensive perspective to health care.”

- A board of nursing defines an NP as follows: “A nurse practitioner (NP) is an RN [registered nurse] who has earned a separate license as an NP through additional education and experience in a distinct specialty area of practice. Nurse practitioners may diagnose, treat, and prescribe for a patient’s condition that falls within their specialty areas of practice. This is done in collaboration with a licensed physician qualified in the specialty involved and in accordance with an approved written practice agreement and protocols. Nurse practitioners are autonomous and do not practice under the supervision of the collaborating physician.”

- According to federal law, “Nurse practitioner means a nurse practitioner who performs such services as such individual is legally authorized to perform (in the state in which the individual
performs such services) in accordance with state laws and who meets such training, education, and experience required as the Secretary has prescribed in regulations” [42 U.S.C.A. § 1395x(aa)(5)(A)].

- In California state law, “nurse practitioner means a registered nurse who possesses additional preparation and skills in physical diagnosis, psych-social assessment, and management of health-illness needs in primary health care and who has been prepared in a program conforming to board standards as specified in Section 1484” [CAL. CODE REGS. tit. 16, § 1480(a)].

For state-by-state definitions of the term nurse practitioner, see Appendix 1-A.

**An NP, by Any Other Name . . .**
Other designations sometimes given to NPs include physician extender, mid-level practitioner, nonphysician practitioner, and advanced practice nurse. For a state-by-state listing of official terms for NPs, see Appendix 1-B.

**Physician Extender**
The term physician extender is used by physicians’ associations and publications aimed at the physician market and usually refers collectively to
NPs, clinical nurse specialists, nurse anesthetists, nurse midwives, and physician assistants.

**Mid-Level Practitioner**
The term *mid-level practitioner* is used by some physician groups, some states, and the federal government in the Code of Federal Regulation sections dealing with Drug Enforcement Administration (DEA) registration. The DEA defines a mid-level practitioner as follows:

The term mid-level practitioner means an individual practitioner other than a physician, dentist, veterinarian, or podiatrist, who is licensed, registered, or otherwise permitted by the United States or the jurisdiction in which he/she practices to dispense controlled dangerous substances in the course of professional practice. Examples of mid-level practitioners include, but are not limited to, healthcare providers such as nurse practitioners, nurse midwives, nurse anesthetists, clinical nurse specialists, and physician assistants who are authorized to dispense controlled
substances by the state in which they practice.

*Citation:* 21 C.F.R. § 1300.01(b).

Some state laws provide a definition of mid-level practitioner. For example, in Minnesota, “‘Mid-level practitioner’ means a nurse practitioner, nurse midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant” [MINN. STAT. § 144.1501(f)].

**Nonphysician Practitioner**

The term *nonphysician practitioner* is used by the Centers for Medicare & Medicaid Services and Medicare administrative contractors. Here is the definition from one administrator’s website:

For Medicare purposes, the term nonphysician practitioner (NPP) includes:

- Nurse practitioner or clinical nurse specialist, as those terms are defined in section 1861(aa)(5) of the Social Security Act, who is working in collaboration with the physician in accordance with State law
Certified nurse–midwife, as defined in section 1861(gg) of the Social Security Act, as authorized by State law

A physician assistant, as defined in section 1861(aa)(5) of the Social Security Act, under the supervision of the physician

Advanced Practice Nurse

*Advanced practice nurse* is an umbrella term used by some states and some nursing associations to cover, collectively, NPs, clinical nurse specialists, nurse–midwives, and nurse anesthetists. NPs differ from other advanced practice nurses in that they offer a wider range of services to a wider portion of the population. Other advanced practice nurses compare with NPs in the following ways:

- **Nurse anesthetist**: Narrow range of services (preoperative assessment, administration of anesthesia, management of postanesthesia recovery) to a narrow base of patients (people having anesthesia).

- **Clinical nurse specialist**: Medium range of services (consultation, research, education, administration, coordination of care, case management, direct care within the definition of a registered nurse) to a narrow patient base (people under the care of a medical specialist).
Certified nurse–midwife: Narrow range of services (well-women gynecologic care, management of pregnancy and childbirth, antepartum and postpartum care) to a medium-sized base of patients (childbearing women).

Nurse practitioner: Wide range of services (evaluation, diagnosis, treatment, education, risk assessment, health promotion, case management, coordination of care, counseling) to a wide base of patients, depending on area of certification; a family nurse practitioner can have a patient base of any age, gender, or problem.

**Services Provided by NPs**

NPs may perform any service authorized by a state nurse practice act. Some nurse practice acts are so broad as to allow any service agreed on by an NP and a collaborating physician. Generally, NP services include:

- Obtaining medical histories and performing physical examinations
- Diagnosing and treating health problems
- Ordering and interpreting laboratory tests and X-rays
- Prescribing medications and other treatments
- Providing prenatal care and family planning services
- Providing well-child care and immunizations
- Providing gynecologic examinations and Pap smears
- Providing education about health risks, illness prevention, and health maintenance
- Providing counseling regarding the need for compliance with a diagnostic and/or treatment plan, course of illness, side effects of treatment, and/or prognosis
- Coordinating care and case management

Typically, an NP has the following duties and responsibilities:

- Conducts comprehensive medical and social history of individuals, including those who are healthy and those with acute illnesses and chronic diseases
- Conducts physical examination of individuals, either comprehensive or problem focused
- Orders, performs, and interprets laboratory tests for screening and for diagnosing
- Prescribes medications
- Performs therapeutic or corrective measures, including urgent care, tertiary care, or critical care
- Refers individuals to appropriate specialist nurses, physicians, or other healthcare providers
- Makes independent decisions regarding management and treatment of medical problems
identified

- Performs various invasive/clinical procedures, such as suturing, biopsy of skin lesions, and endometrial biopsy, depending on education, training, patient needs, and written agreement with physician collaborator
- Prescribes and orders appropriate diet and other forms of treatment, such as physical therapy
- Provides information, instruction, and counseling on health maintenance, health promotion, social problems, illness prevention, illness management, and medication use
- Evaluates the effectiveness of instruction and counseling and provides additional instruction and counseling as necessary
- Initiates and participates in research studies and projects
- Teaches groups of clients about health-related topics
- Provides outreach health education services in the community
- Serves as preceptor for medical, nursing, NP, or physician assistant students
- Accepts after-hours calls and handles after-hours problems on a rotating schedule
- Participates in development of pertinent health education materials
- Participates in development of clinical practice guidelines
- Initiates and maintains follow-up of noncompliant patients
- Makes client home visits and provides care in the home as necessary
- Makes hospital visits and follows hospital care of established patients
- Consults with other healthcare providers about established clients who have been admitted to hospital, home care, rehabilitation, or nursing homes
- Corresponds with insurers, employers, government agencies, and other healthcare providers about established clients as necessary
- Manages care of clients; develops plan of treatment and/or follow-up and monitors progress, determines when referral to another provider is necessary, makes necessary arrangements for further care, determines when hospital admission or emergency room visit is necessary, and determines when illness is resolved
- Assesses social/economic factors for each client and tailors care to those factors
- Manages care of clients in a way that balances quality and cost
• Tracks outcome of interventions and alters interventions to achieve optimum results
• Obtains informed consent from clients as appropriate and necessary
• Maintains familiarity with community resources and connects clients with appropriate resources
• Contracts with clients regarding provider responsibilities and client responsibilities
• Supervises and teaches registered nurses and nonlicensed healthcare workers
• Participates in community programs and health fairs, school programs, and workplace programs
• Represents the practice or the profession as an NP before local and state governing bodies, agencies, and private businesses as needed

**Preparation and License Requirements**

All NPs are registered nurses (RNs) with education beyond the basic requirements for RN licensure. Most NPs have master’s degrees, and some have doctorates. Master’s degrees for NPs are required by law in 40 states. NPs without master’s degrees have completed a program that meets requirements of state law.

State-required qualifications vary widely. For example, in Alaska, NPs must have completed a 1-year academic course, have an RN license, be
certified by a national certifying agency, and have 30 hours of continuing education every 2 years. In Pennsylvania, NPs must have an RN license, a master’s degree, and certification by a national organization; must provide evidence of continuing competence in medical diagnosis and therapeutics; and must have 30 hours of continuing education per year and 45 hours of advanced pharmacology. Federal law defers to state law regarding NP qualifications (42 C.F.R. § 440.166).

In 45 states, NPs are required by state law to take and pass a national certification exam. A state requirement that an NP be nationally certified leads to a requirement of master’s education because the certifying agencies of adult and pediatric NPs require a master’s degree to sit for the certification examination.

**Initials**

Among the initials used to designate NPs are CRNP (certified registered nurse practitioner); ANP-C (adult nurse practitioner–certified); CPNP (certified pediatric nurse practitioner); CGNP (certified geriatric nurse practitioner); RN, CS (registered nurse, certified specialist); ARNP (advanced registered nurse practitioner); and APRN (advanced practice registered nurse).
Areas of Practice

NPs may be certified in the following areas:

- Adult primary care
- Family primary care
- Geriatric primary care
- Neonatal care
- Obstetrics and gynecology
- Pediatric primary care
- Pediatric acute care
- Acute care
- Primary care of school-aged children
- Family planning
- Emergency health care
- Maternal child health
- Mental health/psychiatric care
- Critical care
- Oncology
- Palliative care
- Rehabilitation
- Community health
- Occupational health

Not all categories are recognized in all states.

According to the APRN Consensus Model (2008):

APRNs are educated in one of the four roles and in at least one of six
population foci: family/individual across the lifespan, adult-gerontology, neonatal, pediatrics, women’s health/gender-related, or psych/mental health.\textsuperscript{5}

**Legal History of NPs**
Before the emergence of advanced practice nurses, the legal scope of nurses’ practice excluded the diagnosis and treatment of medical problems. Nurses carried out physicians’ orders. In the mid-1970s, some state nurse practice acts were amended to include “nursing diagnoses” in the scope of nursing practice. A nursing diagnosis “limits the diagnostic process to the diagnoses that represent human responses to actual or potential health problems that are within the legal scope of nursing practice.”\textsuperscript{6}

When a physician shortage arose in the 1960s, it became evident that the shortage and the limitations on nurses’ making medical diagnoses were restricting access to health care for people in medically underserved areas. Certain nurses and physicians joined forces to solve the problem. One answer was the NP.
The first NP educational program was a joint effort between Henry K. Silver, a pediatrician, and Loretta C. Ford, then a nursing professor, at the University of Colorado in 1965. Their project was one of many efforts to deal with a physician shortage. The first NPs began practicing in the late 1960s.

As the concept was envisioned, NPs would make not only nursing diagnoses but also medical diagnoses. Further, they would treat patients with medical therapeutics, ordering pharmacotherapeutics and other treatments. It became necessary to broaden the legal scope of nursing practice.

As soon as NPs began to emerge from the training programs, a body of law emerged governing NP licensure and scope of practice. Idaho was the first state to revise its regulations to allow diagnosis and treatment by nurses.

By the mid-1970s, state legislators began to consider proposed laws regarding prescriptive authority for NPs. In some states, the prescriptive authority was granted through the regulatory process; in others, it was granted through the legislative process. By 2006, NPs had achieved some degree of prescriptive privileges in all states.
and the District of Columbia. The main legal goal of NPs for 30 years was achieved. The next legal hurdle became evident with the enrollment of a large percentage of the population into managed-care plans. While NPs had the authority to bill for services to patients covered by Medicare and Medicaid, they were not necessarily credentialed as providers by the managed-care plans. So NPs met with executives at managed-care organizations and attempted to persuade them to allow NPs to be “primary care providers” for the plans. As of 2013, that had been achieved, for the most part, in most states. The next legal hurdle is achieving the legal authority to medically manage patients within an NP’s scope of practice, without mandated physician collaboration. While NPs in some states may practice without a collaborative practice agreement with a physician, the majority of states still require some form of physician involvement in NP practice.

As of the publication date of this book, NPs in 23 states and the District of Columbia may practice without a mandate of physician collaboration or supervision. In some of these states, an initial period of mentorship or collaboration is required. However, the federal statute governing Medicare still requires NPs to collaborate with a physician.

Demographics
There are over 222,000 NPs in the United States, according to the American Association of Nurse Practitioners.\(^2\)

**NPs in Primary Care**
The concept of the NP emerged from a need for more primary care providers in underserved areas of the nation. While many NPs work in specialty and acute care settings, many provide primary care.

Because health plans designate certain generalist physicians—pediatricians, internists, and family practitioners—as primary care providers (PCPs) for groups of patients, it is important for NPs to be included in the definition of PCP. It is also important for NPs to be included as providers who can be a “medical home” for a patient.

**Definition of Primary Care**
The following are definitions of primary care. According to a national health policy think tank, the National Academy of Sciences’ Institute of Medicine,

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Primary care is the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large
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majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community.⁷

A nurse practice act written by a state agency defines primary health care as:

that which occurs when a consumer makes contact with a healthcare provider who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease. [Cal. Code Regs. tit. 16, § 1480(b)]

A state legislature’s definition is:

the health care which clients receive at the first point of contact with the healthcare system and [that] is continuous and comprehensive. Primary health care includes health promotion, prevention of disease and disability, health maintenance, rehabilitation, identification of health problems, management of health
problems, and referral. [Code Me. R. § 02 380 008(G)]

The American Academy of Family Physicians has five definitions of primary care. One of them acknowledges that providers other than physicians provide primary care.8

Primary care itself is not controversial. Who performs primary care is somewhat controversial. Who receives reimbursement for primary care can be very controversial.

**Legal Authority of NPs to Be Primary Care Providers**

Some state laws specifically authorize NPs to be PCPs, that is, to be designated as the individual responsible for the primary care of a patient enrolled in a managed-care plan.

An example of one such law is Maryland’s, which provides that “each member [of a health maintenance organization] shall have an opportunity to select a primary physician or a certified nurse practitioner from among those available to the health maintenance organization. . .” (Md Health-General Code Ann. § 19-705.1).
In Maryland, a clause in the state law governing health maintenance organizations had been construed as prohibiting anyone other than a physician from being a PCP. Maryland NPs went to the legislature asking for a change in that law. In 2003, the change was made, and the language cited here was enacted.

In some states, no law prohibits an NP from being designated as a PCP.

**NPs as Team Members in Secondary and Tertiary Care**
Whereas the role of NP was originally contemplated to be in primary care, more and more NPs are working for specialists and in hospitals. For those NPs, state law on scope of practice and reimbursement and federal law on reimbursement are most relevant.

**NP Versus Physician Assistant: What Is the Difference?**
While NPs and physician assistants (PAs) may function very similarly and may, in some states, be interchangeable in terms of job description, there are differences between them in legal definition, scope of practice, licensure, and independence of practice. PAs practice medicine under the
supervision of a physician, never independently, as far as the law is concerned. PAs are true physician extenders. NPs practice under their own licenses and in some states may practice independent of physician involvement. NPs may be physician extenders or practice independently, depending on state law.

**Definition and Scope of Practice of PAs Compared with NPs**

By definition, a PA is a healthcare provider who practices medicine with physician supervision. NPs define themselves as nurses with a broadened scope of practice and do not define themselves as physician-supervised professionals.

PAs include in descriptions of their duties taking medical histories, performing physical examinations, ordering and interpreting laboratory tests, diagnosing and treating illnesses, assisting at surgery, prescribing and/or dispensing medication, and counseling patients. NPs would include all of these activities in their scope of practice, with the exception of assisting in surgery. While some NPs assist in surgery under practice agreements with physicians, it is not so common an activity that it is universally included in the scope of practice of NPs. NPs usually include special attention to healthcare
maintenance and illness prevention in their statements of scope of practice. The nurse practice act of at least one state, Oregon, includes hospital admission in the scope of NP practice.

The scope of a PA’s practice corresponds with a supervising physician’s practice, with the understanding that the supervising physician will handle the more complicated medical cases. PAs are authorized to prescribe medications in all 50 states, the District of Columbia, and Guam.\textsuperscript{9}

**Physician Involvement with PA Practice**
Traditionally, PAs acknowledged their status as physician extenders—that they practiced with physician supervision. However, the PA organizations recently have adopted language that emphasizes that PAs practice medicine as part of teams, downplaying the word “supervision.” State law describes the extent to which PAs must practice under physician supervision.\textsuperscript{9}

**Demographics**
As of June 2016, there were approximately 108,500 individuals in clinical practice as PAs.\textsuperscript{9}

**Education**
PAs are educated in programs that use the medical model and are designed to complement physician training. The American Academy of Physician Assistants describes PA education in the following way: PA education includes instruction in core sciences including anatomy, physiology, biochemistry, pharmacology, physical diagnosis, pathophysiology, microbiology, clinical laboratory science, behavioral science, and medical ethics. PAs also complete more than 2,000 hours of clinical rotations, with an emphasis on primary care in ambulatory clinics, physician offices, and acute or long-term care facilities. Rotations include family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry.  

**Licensure Requirements**
According to the American Academy of Physician Assistants, before PAs can practice, they must graduate from an accredited program, pass a certification exam, and become licensed by the state in which they wish to practice.  

**Certification Requirements**
To maintain national certification, PAs must log 100 hours of continuing medical education (CME) every 2 years. CME requirements to maintain state
authorization to practice vary from state to state. PAs sit for recertification every 6 years. See Table 1-1 for a comparison of PAs, NPs, and physicians according to basic and continuing education.

**History of PAs**
As with NPs, the birth of the concept of PAs came after a physician shortage was recognized in the mid-1960s. Dr. Eugene Stead of Duke University Medical Center established the first PA program, using already trained navy corpsmen. He based his program on a fast-track training program for physicians during World War II.

**Table 1-1** Nurse Practitioners’ Education, License, and Certification Contrasted with That of Other Primary Care Providers

<table>
<thead>
<tr>
<th>Health Professional</th>
<th>Years of College</th>
<th>Undergraduate Degree or Other Education</th>
<th>Graduate Degree</th>
<th>License</th>
<th>Continuing Education (Minimum)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse practitioner</td>
<td>2–4</td>
<td>AA, BS, or RN diploma</td>
<td>Master’s degree or doctorate required in 40 states</td>
<td>Yes (RN plus specific area of NP certification)</td>
<td>75 hours/5 years</td>
</tr>
<tr>
<td>Physician</td>
<td>2–4</td>
<td>BS or certificate</td>
<td>Not</td>
<td>Yes</td>
<td>100 hours/2 years</td>
</tr>
</tbody>
</table>
NP Versus Physician: What Is the Difference?
NPs differ from physicians in definition, scope of practice, and education.

Definition and Scope of Practice of Physicians
A physician is a provider of medical care according to the laws of the individual states. An example of
state law defining the practice of medicine is New Jersey’s statute:

The phrase “the practice of medicine or surgery” and the phrase “the practice of medicine and surgery” shall include the practice of any branch of medicine and/or surgery and any method of treatment of human ailment, disease, pain, injury, deformity, mental or physical condition, and the term “physician and surgeon” or “physician or surgeon” shall be deemed to include practitioners in any branch of medicine and/or surgery or method of treatment of human ailment, disease, pain, injury, deformity, mental or physical condition. Within the meaning of this act, except as herein otherwise specifically provided, and except for the purposes of the exemptions hereinafter contained in Sections 45:9-14.1 to 45:9-14.10, inclusive, the practice of medicine and/or surgery shall be deemed to include the inter alia, the practice of osteopathy . . . .

*Citation:* N.J. STAT. ANN. § 45:9-5.1.
Educational Requirements of Physicians
Physicians have 4 years of medical education. See Table 1-1 for a comparison of NPs, physicians, and PAs on requirements for basic education, continuing education, licensure, and certification.

NP Versus RN: What Is the Difference?
NPs and RNs differ in definition, scope of practice, education, and physician supervision.

Definition of RN
The legal definition of an RN is provided by the laws of the states. Michigan, for example, defines nursing and registered nurse as follows:

The “practice of nursing” means the systematic application of substantial specialized knowledge and skill derived from the biological, physical, and behavioral sciences, to the care, treatment, counsel, and health teaching of individuals who are experiencing changes in the normal health processes or who require assistance in the maintenance of health and the prevention or
management of illness, injury, or disability. . . . “Registered professional nurse” or “RN” means an individual licensed under this article to engage in the practice of nursing which scope of practice includes the teaching, direction, and supervision of less skilled personnel in the performance of delegated nursing activities.

_Citation_: Mich. Comp. Laws § 333.17201.

**Scope of Practice of RNs**

Nursing typically includes a variety of acts, described under state law. The nursing acts described here are taken from the law of North Dakota:

The performance of acts utilizing specialized knowledge, skills, and abilities for people in a variety of settings. The term includes the following acts, which may not be deemed to include acts of medical diagnosis or treatment or the practice of medicine as defined in Chapter 43–17.
a. The maintenance of health and prevention of illness
b. Diagnosing human responses to actual or potential health problems
c. Providing supportive and restorative care and nursing treatment, medication administration, health counseling and teaching, case finding and referral of persons who are ill, injured, or experiencing changes in the normal health processes
d. Administration, teaching, supervision, delegation, and evaluation of health and nursing practices
e. Collaboration with other healthcare professionals in the implementation of the total healthcare regimen and execution of the healthcare regimen prescribed by a healthcare practitioner licensed to order healthcare regimens
Education of RNs
An RN has 2–4 years of college education and may have a master’s degree, a doctorate, or other advanced training over and above the basic education.

Supervision of RNs
Supervision is generally not mandated by law for those activities within the scope of nursing practice. To provide medical care, such as administering prescription medication, an RN needs an order from a healthcare provider authorized by law to give orders or prescribe medication.

NP Versus Clinical Nurse Specialist: What Is the Difference?
While both NPs and clinical nurse specialists (CNSs) are advanced practice nurses, they focus on different forms of patient care. While NPs manage patients in offices, nursing facilities, homes, and hospitals, CNSs traditionally have worked in hospitals, as resources for other clinicians. Psychiatric/mental health CNSs traditionally have performed direct patient care, as therapists. In the past 10 years, programs for psych/mental health
NPs have emerged, so now, both NPs and CNSs manage patients with psychiatric diagnoses. The distinction between CNSs and NPs is important to advanced practice nurses, but probably not so important to those who are not in the field.

**Definition and Scope of Practice of CNSs**

The definition and scope of practice of a CNS are specified by state law. For example, Maine law defines the scope of practice of a CNS as follows:

The certified clinical nurse specialist applies research-based knowledge, skills, and experience to intervene in human responses to complex health and illness problems. The certified clinical nurse specialist (1) provides case management skills to coordinate comprehensive health services and ensure continuity of care, (2) evaluates client progress in attaining expected outcomes, (3) consults with other healthcare providers to influence care of clients, effect change in symptoms, and enhance the ability of others to provide health care, (4) performs additional functions specific
to the specialty areas. In addition to the above, the certified psychiatric clinical nurse specialist may independently assess, diagnose, and therapeutically intervene in complex mental health problems using psychotherapy and other interventions.

_Citation:_ CODE ME. R. § 02 380 Chapter 8.

**Education of CNSs**
CNSs have, at minimum, a master’s degree in nursing and may have a doctorate.

**Physician Supervision of CNSs**
CNSs have no requirement for physician supervision unless they have prescriptive authority, in which case there often are collaboration or supervision requirements specified by state law. See Table 1-2 for a comparison of NPs, CNSs, and other types of advanced practice nurses in terms of education and licensure.

**Table 1-2** Nurse Practitioners’ Educational and Professional Credentials Contrasted with Those of Other Advanced Practice Nurses
<table>
<thead>
<tr>
<th>Type of APN</th>
<th>Years of College</th>
<th>Years of Training</th>
<th>Undergraduate Degree</th>
<th>Graduate Degree</th>
<th>License</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse anesthetist</td>
<td>4</td>
<td>2</td>
<td>BA/BS</td>
<td>Master’s degree</td>
<td>Yes, RN plus nurse anesthetist</td>
</tr>
<tr>
<td>Nurse–midwife</td>
<td>4</td>
<td>2</td>
<td>BA/BS</td>
<td>Master’s degree or doctorate</td>
<td>Yes, RN plus nurse–midwife</td>
</tr>
<tr>
<td>Nurse psychotherapist</td>
<td>4</td>
<td>2, plus 100 hours of supervised practice</td>
<td>BA/BS</td>
<td>Master’s degree</td>
<td>Yes, RN plus nurse psychotherapist</td>
</tr>
<tr>
<td>Nurse practitioner</td>
<td>4</td>
<td>2</td>
<td>BA/BS</td>
<td>Master’s degree or doctorate required in 32 states</td>
<td>Yes, RN plus nurse practitioner</td>
</tr>
</tbody>
</table>

Abbreviations: APN, advanced practice nurse; AMCB, American Midwifery Certification Center; BA, bachelor of arts degree; BS, bachelor of science degree; CRNA, certified registered nurse anesthetist; NBCRNA, National Board of Certification and Recertification of Nurse Anesthetists; NCC, National Certification Corporation; NP, nurse practitioner; PNCB, Pediatric Nursing Certification Board; RN, registered nurse.

Data from the American Nurses Credentialing Center, American Association of Nurse-Midwives websites.
Where Do Nurse Practitioners Practice?
NPs practice in health maintenance organizations, independent or collaborative private practices, hospitals and affiliated clinics, emergency departments, family planning clinics, college health services, school clinics, convenient care clinics, employee health clinics, nursing and long-term care facilities, homeless shelters, hospices, and home-based care services.

The NP Doctorate
The Doctor of Nursing Practice (DNP) degree emerged as an option for NPs in the first decade of this century. It is for those NPs who want a terminal degree but want to maintain a clinical, policy, or operations focus rather than produce, analyze, and evaluate research. Some DNP programs are aimed at those who already have a master’s degree in nursing. Others are for those with bachelor’s degrees in nursing who will go straight through for a doctorate. Some universities admit both types of students for the DNP. Individuals who don’t already have a master’s degree will need more credit hours for completion.

The DNP emerged for some of these reasons:
PhDs and DNSs create the evidence base for nursing, but it was felt there was a need for clinicians who had advanced competencies other than research expertise to provide NP leadership within complex healthcare systems.

- A need for enhanced knowledge about information systems and technology for the purpose of improving nursing practice and patient outcomes.
- A need to translate research findings into clinical practice.
- A need for NPs who understand health policy.
- A desire by NPs who wanted to continue as clinicians and wanted more education to have a suitable terminal degree that reflected their education.

Curricula vary among DNP programs. One might find course content on:

- Quantitative methods for evaluating healthcare practices.
- Financial management and budget planning.
- Data-driven healthcare improvement.
- Evidence-based practice.
- Effective leadership.
- Scholarly writing.
- Transforming the nation’s health.
- Health systems transformation.
The programs require a “capstone project,” that is, in the final year DNP candidates take what they have learned and apply it to examine, in writing, a specific idea applicable to health care.

While the DNP was originally thought to be a “clinical doctorate,” the curricula in most programs have been oriented less toward pathophysiology and pharmacology and more toward policy, meta-analysis of research, and systems studies. The DNP is not equivalent to a medical doctorate.

There is very little law on DNPs. In some states, the degree is listed as one of the educational credentials a successful applicant for a license as an NP might have. But while 40 states require NPs to have master’s degrees, no state requires an NP to have a doctorate.

In offering the DNP, the nursing profession is moving in the direction of other clinical health professions. Not only is there a doctorate in medicine (MD) and dentistry (DDS), but also in Pharmacy (PharmD), Psychology (PsyD), Physical Therapy (DPT), and Audiology (AudD).

NPs should understand that they are not required to get a doctorate to practice or keep practicing. There
has been much confusion about this issue, and here is why: In 2004 the American Association of Colleges of Nursing (AACN) recommended that the doctorate be the entry-into-practice degree for advanced practice nursing and that the target date for the implementation of this recommendation be 2015. In 2008, a group called the Nurse Practitioner Roundtable issued a statement in support of the DNP, implying that it could or should replace the master’s degree in nursing, saying:

The DNP degree more accurately reflects current clinical competencies and includes preparation for the changing health care system. It is congruent with the intense rigorous education for nurse practitioners. This evolution is comparable to the clinical doctoral preparation for other health care professions. 

The Roundtable did not specify a target date for the change. Also, in 2008, a large group of nursing organizations got together to discuss goals for standardizing state requirements for advanced practice. That group addressed licensing, accreditation, certification, and educational requirements and produced a document “Consensus Model for APRN Regulations: Licensure, Accreditation, Certification & Education.”
The document is available on the website of the National Council of State Boards of Nursing (NCSBN): www.ncsbn.org. The consensus model mentioned the doctorate as an appropriate educational preparation for advanced practice, along with the master’s degree, but did not recommend that the doctorate replace the master’s degree for entry into practice. The consensus model set a target of 2015 for the regulatory changes it recommended. On hearing about the consensus model, as well as the AACN recommendation and Nurse Practitioner Roundtable comments, some NPs thought they would be required to get a doctorate by 2015. That is not so.

Legislatures and boards of nursing set the educational standards for advanced practice nursing. Associations and organizations can make recommendations, but cannot make laws. Association and organization recommendations are simply recommendations that a legislature can accept or ignore. Obviously 2015 has passed, and as of the 2016 deadline for publication of this edition, the organizations’ recommendation regarding the DNP has not been adopted. No state requires a doctorate for NP practice for either new NPs or those who are already licensed and certified.
The NP who wants to progress as a faculty member at a university will need a doctorate, and the DNP is one way to fulfill a university’s requirement that assistant professors have terminal degrees. NPs with a DNP are finding executive positions in health facilities and networks and in government. However, it is the rare job description that requires a DNP. And for NPs who want their day to be 100 percent patient care, it is not clear that a DNP will entitle the NP to anything—not a raise, a promotion, or even a job. The DNP is a degree; the role of an NP is something else. Roles for an NP may include healthcare provider, educator, executive, analyst, policy maker, or research team member. At this time, an NP can fulfill those roles with or without a doctorate.

Use of the Title “Doctor”
Once an individual has earned a doctorate, it is natural to want to use that title while at work. Because they hold doctorates, some NP practitioners want to introduce themselves to patients as “Doctor.” This is tricky, legally and ethically, because introducing oneself as “Doctor” in a clinical setting or having “Dr.” before one’s name on a name tag can be misleading. Traditionally, people who introduce themselves as “Doctor” in a healthcare setting have been medical doctors. As
stated earlier, the DNP is not equivalent to an MD. Few “clinical” doctoral programs for nurses turn out individuals who have completed doctoral-level work in diagnosis and therapeutics, pharmacology, immunology, neurophysiology, pathophysiology, histology, pathology, and microbiology. Most NPs with clinical doctorates attended programs heavy on health policy, leadership, quality measurement, and data analysis. Furthermore, most clinical doctorates in nursing do not include a full 2 years of supervised and evaluated medical diagnosis and disease management. Then there is the residency issue. DNPs haven’t completed a residency in medicine. So patients who research the matter may conclude that they have been misled if, for example, their heart failure doctor turns out to be an NP with a doctorate in health policy. Patients who believe they have been misled may create a public relations problem for a practice or facility.

Furthermore, in some states it is illegal for anyone to use the title “Doctor” unless the person is a medical doctor. The crime would be practicing medicine without a license. Here is Ohio’s law:

A person shall be regarded as practicing medicine and surgery, osteopathic medicine and surgery, or
podiatric medicine and surgery, within the meaning of this chapter, who does any of the following:

1. Uses the words or letters, “Dr.,” “Doctor,” “M.D.,” “physician,” “D.O.,” “D.P.M.,” or any other title in connection with the person’s name in any way that represents the person as engaged in the practice of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, in any of its branches. . . .

Citation: OHI0 REV. CODE 4731.34: (A) and (B).

Some hospitals have policies on who may use the title “Doctor.” For NPs who have completed truly clinical doctorates (such as heart failure NPs who have devoted all of their doctoral efforts to learning about management of heart failure), it may be worthwhile to challenge a facility policy or state law. That would mean presenting the issue to decision makers and asking for a change. One would need to
describe the DNP’s curriculum and compare it with a local medical school’s curriculum, and be prepared to argue why the curriculum the DNP completed is as good or better than medical school at preparing a clinician to treat the types of patients the NP is treating. One could argue that although the medical school model is firmly entrenched in our culture, no studies have proven that the medical school model is the only effective model for teaching clinicians how to properly care for patients.

Here is what the Nurse Practitioner Roundtable wrote about using the title “Doctor” by NPs:

1. The title “Doctor” represents an academic credential, and is not limited to professional programs. Graduate educational programs in colleges and universities in the United States confer academic degrees, which permit graduates to be called “doctor”. No one discipline owns the title “doctor”.

2. In the health care field, the term doctor is not limited to medical doctors. Other health care professions use their academic title: e.g. Doctor of Osteopathy, Doctor of Pharmacy, Doctor of Podiatry, Doctor of Psychology, Doctor of Physical Therapy and others.
3. While the titles “Medical Doctor” or “Doctor of Osteopathy” may be title protected by statute in a given state, the term “doctor” alone is not.

4. Recognition of the title “Doctor” for doctorally prepared nurse practitioners facilitates parity within the health care system.¹⁰

How should doctorally prepared NPs who want to communicate their level of education introduce themselves to patients in a clinic or facility? One way is “I am Jennifer Smith, a nurse practitioner. You’ll notice DNP on my name tag. That means I have a doctorate of nursing practice.” The name tag should provide Ms. Smith’s name, degree, and certification, that is, “Jennifer Smith, DNP, ACNP.”

Notes


Appendix 1-A: State-by-State Definitions of Nurse Practitioner

The following are state-by-state definitions of nurse practitioner, including citation of code section.

Alabama

Advanced practice nurse. A registered nurse that has gained additional knowledge and skills through successful completion of an organized program of nursing education that prepares nurses for advanced practice roles and has been certified by the Board of Nursing to engage in the practice of advanced practice nursing.

*Citation: Ala. Code § 34-21-81(3).*

Practice as a certified registered nurse practitioner (CRNP) means the performance of nursing skills by a registered nurse who has demonstrated by certification that he
or she has advanced knowledge and skills in the delivery of nursing services within a health care system that provides for consultation, collaborative management, or referral as indicated by the health status of the client.

_Citation:_ ALA. CODE § 34-21-81(4a).

**Alaska**

“Advanced nurse practitioner” means a registered nurse authorized to practice in the state who, because of specialized education and experience, is certified to perform acts of medical diagnosis and the prescription and dispensing of medical, therapeutic, or corrective measures under regulations adopted by the Board.

_Citation:_ ALASKA STAT. § 08.68.850(1).

**Arizona**

“Registered nurse practitioner” means a registered nurse who:

a. Is certified by the board.
b. Has completed a nurse practitioner education program approved or recognized by the board and educational requirements prescribed by the board by rule.

c. If applying for certification after July 1, 2004, holds national certification as a nurse practitioner from a national certifying body recognized by the board.

d. Has an expanded scope of practice within a specialty area that includes:
   i. Assessing clients, synthesizing and analyzing data, and understanding and applying principles of health care at an advanced level.
   ii. Managing the physical and psychosocial health status of clients.
   iii. Analyzing multiple sources of data, identifying alternative
possibilities as to the nature of a healthcare problem and selecting, implementing and evaluating appropriate treatment.

iv. Making independent decisions in solving complex client care problems.

v. Diagnosing, performing diagnostic and therapeutic procedures, and prescribing, administering and dispensing therapeutic measures, including legend drugs, medical devices, and controlled substances within the scope of registered nurse practitioner practice on meeting the requirements established by the board.

vi. Recognizing the limits of the nurse’s knowledge and experience and planning for situations
beyond the nurse’s knowledge, educational preparation and expertise by consulting with or referring clients to other healthcare providers when appropriate.

vii. Delegating to a medical assistant pursuant to § 32-1456.

viii. Performing additional acts that require education and training as prescribed by the board and that are recognized by the nursing profession as proper to be performed by a nurse practitioner.

_Citation:_ ARIZ. REV. STAT. ANN. § 32-1601(20).

**Arkansas**

(a)(1) Any person holding a license to practice as a registered nurse and possessing the educational
qualifications required under subsection (b) of this section to be licensed as a registered nurse practitioner may, upon application and payment of necessary fees to the Arkansas State Board of Nursing, be licensed as a registered nurse practitioner and have the right to use the title of “registered nurse practitioner” and the abbreviation “RNP.”

(2) No other person shall assume such a title or use such an abbreviation or any other words, letters, signs, or devices to indicate that the person using them is a registered nurse practitioner.

(b) In order to be licensed as a registered nurse practitioner, a registered nurse must hold a certificate or academic degree evidencing successful completion of the educational program of an accredited school
of nursing or other nationally recognized accredited program recognized by the board as meeting the requirements of a nurse practitioner program.

_Citation:_ ARK. CODE ANN. § 17-87-303.

**California**

The Legislature finds that various and conflicting definitions of the nurse practitioner are being created by state agencies and private organizations within California. The Legislature also finds that the public is harmed by conflicting usage of the title of nurse practitioner and lack of correspondence between use of the title and qualifications of the registered nurse using the title. Therefore, the Legislature finds the public interest served by the determination of the legitimate use of the title “nurse practitioner” by registered nurses.

_Citation:_ CAL. BUS. & PROF. CODE § 2834.
“Nurse practitioner” means a registered nurse who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program conforming to board standards as specified in Section 1484.

Citation: CAL. CODE REGS. tit. 16, § 1480(a).

Colorado

“Practice of advanced practice nursing” means an expanded scope of professional nursing in a scope, role, and population focus approved by the board, with or without compensation or personal profit, and includes the practice of professional nursing, as defined in subsection (10) of this section.

Citation: COLO. REV. STAT. ANN. § 12-38-103-8.5a.
The board shall establish the advanced practice registry and shall require that a nurse applying for registration identify his or her role and population focus. The board shall establish reasonable criteria for designation of specific role and population foci based on currently accepted professional standards. A nurse who is included in the advanced practice registry has the right to use the title “advanced practice nurse” or, if authorized by the board, to use the title “certified nurse midwife”, “clinical nurse specialist”, “certified registered nurse anesthetist”, or “nurse practitioner”. These titles may be abbreviated as “A.P.N.”, “C.N.M.”, “C.N.S.”, “C.R.N.A.”, or “N.P.”, respectively. It is unlawful for any person to use any of the titles or abbreviations listed in this subsection (3) unless included in the registry and authorized by the board to do so.

*Citation: Colo. Rev. Stat. Ann. § 12-38-111.5(3).*
Connecticut
Advanced nursing practice is defined as the performance of advanced level nursing practice activities that, by virtue of post-basic specialized education and experience, are appropriate to and may be performed by an advanced practice registered nurse. The advanced practice registered nurse performs acts of diagnosis and treatment of alterations in health status, as described in subsection (a) of this section.

Citation: CONN. GEN. STAT. ANN. § 20-87a(b)(1).

Delaware
“Advanced practice nurse” means an individual whose education and certification meet criteria established by the Board of Nursing, who is currently licensed as a registered nurse, and has a master’s degree or a postbasic program certificate in a clinical nursing specialty with national certification. When no national certification at the advanced level
exists, a master’s degree in a clinical nursing specialty will qualify an individual for advanced practice nurse licensure. “Advanced practice nurse” shall include nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, or clinical nurse specialists. Advanced practice nursing means the “practice of professional nursing”, as defined in this section.

“Advanced practice registered nurse” (“APRN”) means an individual with knowledge and skills acquired in basic nursing education; licensure as an RN; and graduation from or completion of a graduate level APRN program accredited by a national accrediting body and current certification by a national certifying body in the appropriate APRN role and at least 1 population focus. “Advanced practice registered nurse” shall include certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, or clinical nurse specialists. Advanced practice nursing means an
expanded scope of nursing in a role and population focus approved by the Board of Nursing, with or without compensation or personal profit, and includes the RN scope of practice. The scope of an APRN includes, but is not limited to, performing acts of advanced assessment, diagnosing, prescribing, and ordering. Advanced practice nursing is the application of nursing principles, including those described in subsection (x) of this section, at an advanced level and includes:

a. For those advanced practice nurses who do not perform independent acts of diagnosis or prescription, the authority as granted within the scope of practice rules and regulations promulgated by the Board of Nursing; and

b. For those advanced practice nurses performing independent acts of diagnosis and/or prescription with the collaboration of a licensed physician, dentist, podiatrist, or
licensed Delaware health care delivery system without written guidelines or protocols and within the scope of practice as defined in the rules and regulations promulgated by the Joint Practice Committee and approved by the Board of Medical Licensure and Discipline.

_Citation_: DEL. CODE ANN. tit. 24, § 1902 (b)–(c)(1).

**District of Columbia**

“Practice of advanced practice registered nursing” means the performance of advanced-level nursing actions, with or without compensation, by a licensed registered nurse with advanced education, knowledge, skills, and scope of practice who has been certified to perform such actions by a national certifying body acceptable to the Board of Nursing. The practice of advanced practice registered nursing includes:
A. Advanced assessment;  
B. Medical diagnosis;  
C. Prescribing;  
D. Selecting, administering, and dispensing therapeutic measures;  
E. Treating alterations of the health status; and  
F. Carrying out other functions identified in title VI of this act and in accordance with procedures required by this act.

*Citation:* D.C. STAT. § 3-1201.02 (2).

**Florida**

“Advanced registered nurse practitioner” means any person licensed in this state to practice professional nursing and certified in advanced or specialized nursing practice, including certified registered nurse anesthetists, certified nurse midwives, and nurse practitioners.

*Citation:* FLA. STAT. ANN. § 464.003(3).

**Georgia**
“Advanced practice registered nurse” means a registered professional nurse licensed under this chapter who is recognized by the board as having met the requirements established by the board to engage in advanced nursing practice and who holds a master's degree or other graduate degree from an approved nursing education program and national board certification in his or her area of specialty, or a person who was recognized as an advanced practice registered nurse by the board on or before June 30, 2006.

*Citation*: GA. CODE ANN. § 43-26-3(1.1).

The advanced practice registered nurse is a certified nurse-midwife (CNM), nurse practitioner (NP), certified registered nurse anesthetist (CRNA), clinical nurse specialist (CNS) or clinical nurse specialist in psychiatric/mental health (CNS/PMH), and is authorized to practice by the Georgia Board of Nursing (“the Board”).
Hawaii

“Advanced practice registered nurse” means a registered nurse who has met the qualifications for advanced practice registered nurse licensure set forth in this chapter and through rules of the board, which shall include educational requirements.

*Citation: HAW. REV. STAT. § 457-2.*

“Advanced practice registered nurse (APRN)” means a registered nurse licensed to practice in this State who has met the qualifications set forth in Chapter 457, HRS, and this subchapter, and who because of advanced education and specialized clinical training, is authorized to assess, screen, diagnose, order, utilize, or perform medical, therapeutic, preventive or corrective measures.

*Citation: HAW. ADMIN. § 16-89-2.*
"Advanced practice registered nurse" means a registered nurse licensed in this state who has gained additional specialized knowledge, skills and experience through a program of study recognized or defined by the board. An advanced practice registered nurse is authorized to perform advanced nursing practice, which may include the prescribing, administering and dispensing of therapeutic pharmacologic agents, as defined by board rules. An advanced practice registered nurse shall perform only those acts as provided by the board and for which the individual is educationally prepared. Advanced practice registered nurses shall include the following four (4) roles: certified nurse-midwife; clinical nurse specialist; certified nurse practitioner; and certified registered nurse anesthetist as defined in board rule. An advanced practice registered nurse collaborates with other health professionals in providing health care.
Illinois

a. Advanced practice nursing by certified nurse practitioners, certified nurse anesthetists, certified nurse midwives, or clinical nurse specialists is based on knowledge and skills acquired throughout an advanced practice nurse’s nursing education, training, and experience.

b. Practice as an advanced practice nurse means a scope of nursing practice, with or without compensation, and includes the registered nurse scope of practice.

c. The scope of practice of an advanced practice nurse includes, but is not limited to, each of the following:

   1. Advanced nursing patient assessment and diagnosis.

   2. Ordering diagnostic and therapeutic tests and
procedures, performing those tests and procedures when using health care equipment, and interpreting and using the results of diagnostic and therapeutic tests and procedures ordered by the advanced practice nurse or another health care professional.

3. Ordering treatments, ordering or applying appropriate medical devices, and using nursing medical, therapeutic, and corrective measures to treat illness and improve health status.

4. Providing palliative and end-of-life care.

5. Providing advanced counseling, patient education, health education, and patient advocacy.
6. Prescriptive authority as defined in Section 65-40 of this Act.

7. Delegating selected nursing activities or tasks to a licensed practical nurse, a registered professional nurse, or other personnel.

Citation: ILL. COMP. STAT. § 65/65-30.
[Section scheduled for repeal on January 1, 2018.]

Indiana

“Advanced practice nurse” means (1) a nurse practitioner; (2) a certified nurse midwife; (3) a clinical nurse specialist; or (4) a certified registered nurse anesthetist who is a registered nurse qualified to practice nursing in a specialty role based upon the additional knowledge and skill gained through a formal organized program of study and clinical experience, or the equivalent as determined by the board, which does not limit but extends or expands the function of the
nurse, which may be initiated by the client or provider in settings that shall include hospital outpatient clinics and health maintenance organizations.

*Citation:* Ind. Code Ann. § 25-23-1-1(b).

“Nurse practitioner” means an advanced practice nurse who provides advanced levels of nursing client care in a specialty role, who meets the requirements of the advanced practice nurse as outlined in Section 3 of this rule.

*Citation:* Ind. Admin. Code tit. 848, r. 4-1-4.

**Iowa**

“Advanced registered nurse practitioner (ARNP)” means a nurse with current licensure as a registered nurse in Iowa or who is licensed in another state and recognized for licensure in this state pursuant to the nurse licensure compact contained in 2000 Iowa Acts, House File 2105, section 8, and is also registered in
Iowa to practice in an advanced role. The ARNP is prepared for an advanced role by virtue of additional knowledge and skills gained through a formal advanced practice education program of nursing in a specialty area approved by the board. In the advanced role, the nurse practices nursing assessment, intervention, and management within the boundaries of the nurse-client relationship. Advanced nursing practice occurs in a variety of settings, within an interdisciplinary health care team, which provide for consultation, collaborative management, or referral. The ARNP may perform selected medically delegated functions when a collaborative practice agreement exists.

*Citation: Iowa Admin. Code § r. 655-6.1(152).*

“Certified nurse practitioner” means an ARNP educated in the disciplines of nursing who has advanced knowledge of nursing, physical and psychosocial
assessment, appropriate interventions, and management of health care, and who possesses evidence of current certification by a national professional nursing association approved by the board.

Citation: IOWA ADMIN. CODE § r. 655-6.1(152).

Kansas
“Advanced practice registered nurse” or “APRN” means a professional nurse who holds a license from the board to function as a professional nurse in an advanced role, and this advanced role shall be defined by rules and regulations adopted by the board in accordance with KSA 65-1130, and amendments thereto.

Citation: KAN. STAT. ANN. § 65-1113(g).

Kentucky
“Advanced practice registered nurse” or “APRN” means a certified nurse practitioner, certified registered nurse anesthetist, certified nurse midwife, or
clinical nurse specialist, who is licensed to engage in advance practice registered nursing pursuant to KRS 314.042 and certified in at least one (1) population focus.

Citation: KY. REV. STAT. ANN. § 314.011(7).

Louisiana

“Advanced practice registered nurse” or “APRN” means a licensed registered nurse who is certified by a nationally recognized certifying body, such as the American Nurses Credentialing Center, as having an advanced nursing specialty as described in this Part and who meets the criteria for an advanced practice registered nurse as established by the board. In the absence of the availability of a national certification examination in a selected clinical area, the board may establish commensurate requirements. An advanced practice registered nurse shall include, but not be limited to, the following:
a. Certified nurse midwife or “CNM”
b. Certified registered nurse anesthetist or “CRNA”
c. Clinical nurse specialist or “CNS”
d. Nurse practitioner or “NP”

Citation: LA. REV. STAT. ANN. § 37:913 (1).

Maine

“Advanced practice registered nurse” means an individual who is currently licensed under this chapter to practice advanced practice registered nursing as defined in subsection 2-A. “A.P.R.N.” is the abbreviation for the title of “advanced practice registered nurse.” An advanced practice registered nurse may use the abbreviation “A.P.R.N.” or the title or abbreviation designated by the national certifying body.

“Advanced practice registered nurse” includes a certified nurse practitioner, a certified nurse midwife, a certified
clinical nurse specialist, and a certified nurse anesthetist who are licensed under this chapter to practice advanced practice registered nursing.

_Citation:_ CODE ME. R. § 32-2102(5-A).

**Maryland**

“Nurse practitioner” means a registered nurse who is certified by the Board to practice as a nurse practitioner in accordance with this chapter.

_Citation:_ MD. REGS. CODE § 10.27.07.01.B(5).

**Massachusetts**

Advanced Practice Registered Nurse (APRN) means a currently licensed Massachusetts Registered Nurse (RN) who has current authorization by the Board to engage in advanced practice nurse activities. APRN practice activities include, but are not limited to: advanced assessment, diagnosis, treatment, referrals, consultations, and other modalities for individuals,
groups, or communities across the life span for health promotion or health maintenance and for those who are experiencing acute or chronic disease, illness, trauma or other life-altering event in which rehabilitative, and/or palliative interventions are necessary. APRN practice is defined to include only those activities within the APRN’s authorized clinical category, scope of practice competencies, and accepted standards of Advanced Nursing practice.

Citation: 244 MASS. ADMIN. CODE § 4.02.

Board recognized APRN clinical categories and abbreviations include:

1. Certified Registered Nurse Anesthetist (CRNA);
2. Certified Nurse Midwife (CNM);
3. Certified Nurse Practitioner (CNP);
4. Clinical Nurse Specialist (CNS);
5. Psychiatric Clinical Nurse Specialist (PCNS).
Michigan

The board of nursing may issue a specialty certification to a registered professional nurse who has advanced training beyond that required for initial licensure and who has demonstrated competency through examination or other evaluative processes and who practices in one of the following health profession specialty fields: nurse midwifery, nurse anesthetist, or nurse practitioner.

“Certified nurse practitioner” means an individual licensed as a registered professional nurse under part 172 who has been issued a specialty certification as a nurse practitioner by the board of nursing under Section 17210.
**Minnesota**

“Advanced practice registered nurse,” abbreviated APRN, means an individual licensed as an advanced practice registered nurse by the board and certified by a national nurse certification organization acceptable to the board to practice as a clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner.

*Citation: MICH. COMP. LAWS § 333.2701(c).*

**Mississippi**

An “advanced practice registered nurse” is a person who is licensed or holds the privilege to practice under this article and who is certified in advanced practice registered nurse or specialized nursing practice and includes certified nurse midwives, certified registered nurse anesthetists and certified nurse practitioners. . . . “C.N.P” is the abbreviation for the title of certified nurse practitioner.

*Citation: MINN. STAT. § 148.171(3).*
Missouri

“Advanced practice registered nurse,” a nurse who has education beyond the basic nursing education and is certified by a nationally recognized professional organization as a certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, or a certified clinical nurse specialist. The board shall promulgate rules specifying which nationally recognized professional organization certifications are to be reorganized for the purposes of this section. Advanced practice nurses and only such individuals may use the title “Advanced Practice Registered Nurse” and the abbreviation “APRN.”

Montana

“Advanced practice registered nurse” means a registered professional nurse who has completed educational
requirements related to the nurse’s specific practice role, in addition to basic nursing education, as specified by the board pursuant to 37-8-202.

_Citation:_ MONT. CODE ANN. 37-8-102(1).

**Nebraska**

Nurse practitioner means a registered nurse certified as described in Section 38-2317 and licensed under the Advanced Practice Registered Nurse Practice Act to practice as a nurse practitioner.

_Citation:_ NEB. REV. STAT. § 38-2312.

**Nevada**

“Advanced practice registered nurse” means a registered nurse who has specialized skill, knowledge and experience obtained from an organized formal program of training and who is licensed by the Board and is authorized in special conditions as set forth in NAC 632.254 to 632.295, inclusive, to provide designated services in addition to those which a
registered nurse is authorized to perform.

_Citation:_ **Nev. Admin. Code** § 632.020.

**New Hampshire**

“Advanced practice registered nurse” or “APRN” means a registered nurse currently licensed by the board under RSA 326-B:18.


**New Jersey**

“Advanced practice nurse” means a person who holds a certification in accordance with section 8 or 9 of P.L. 1991, c.377 (C.45:11-47 or 45.11-48).

_Citation:_ **N.J. Stat. Ann.** § 45:11-23.d.

Whenever the titles or designations “nurse practitioner,” “clinical nurse specialist,” or “nurse practitioner/clinical nurse specialist” occur or any reference is made thereto in any law, contract or document, the
same shall be deemed to mean or refer to the title or designation “advanced practice nurse.”

_Citation:_ N.J. S_TAT. _A_NN. § 45:11-46.7.c.

**New Mexico**

“Certified nurse practitioner” means a registered nurse who is licensed by the board for advanced practice as a certified nurse practitioner and whose name and pertinent information are entered on the list of certified nurse practitioners maintained by the board.

_Citation:_ N.M. S_TAT. _A_NN. § 61-3-3.E.

**New York**

The practice of registered professional nursing by a nurse practitioner, certified under section six thousand nine hundred ten of this article, may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures within a specialty area of practice, in collaboration with a
licensed physician qualified to collaborate in the specialty involved, provided such services are performed in accordance with a written practice agreement and written practice protocols.

Citation: N.Y. EDUC. LAW, ART. 139, § 6902.3(a).

North Carolina

“Advanced Practice Registered Nurse (APRN)” means a nurse practitioner, nurse anesthetist, nurse-midwife or clinical nurse specialist.

Citation: N.C. ADMIN. CODE tit. 21, r. § 36.0120(5).

“Nurse Practitioner” or “NP” means a currently licensed registered nurse approved to perform medical acts consistent with the nurse’s area of nurse practitioner academic educational preparation and national certification under an agreement with a licensed physician for ongoing supervision, consultation, collaboration
and evaluation of the medical acts performed. Such medical acts are in addition to those nursing acts performed by virtue of registered nurse (RN) licensure. The NP is held accountable under the RN license for those nursing acts that he or she may perform.

Citation: N.C. Admin. Code tit. 21, r. § 36.0801.

North Dakota

“Advanced practice registered nurse” means an individual who holds a current license to practice in this state as an advanced practice registered nurse within one of the roles of certified nurse practitioner, certified registered nurse anesthetist, certified nurse midwife, or certified clinical nurse specialist, and who functions in one of the population foci as approved by the board.

Citation: N.D. Cent. Code § 43-12.1-02(1).
Ohio

“Certified nurse practitioner” means a registered nurse who holds a valid certificate of authority issued under this chapter that authorizes the practice of nursing as a certified nurse practitioner in accordance with Section 4723.43 of the Revised Code and rules adopted by the board of nursing.

*Citation: Ohio Rev. Code Ann. § 4723.01(J).*

“Advanced practice registered nurse” means a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner.

*Citation: Ohio Rev. Code Ann. § 4723.01(O).*

Oklahoma

“Advanced Practice Registered Nurse” means a licensed Registered Nurse:

a. who has completed an advanced practice registered
nursing education program in preparation for one of four recognized advanced practice registered nurse roles,
b. who has passed a national certification examination recognized by the Board that measures the advanced practice registered nurse role and specialty competencies and who maintains recertification in the role and specialty through a national certification program,
c. who has acquired advanced clinical knowledge and skills in preparation for providing both direct and indirect care to patients; however, the defining factor for all Advanced Practice Registered Nurses is that a significant component of the education and practice focuses on direct care of individuals,
d. whose practice builds on the competencies of Registered Nurses by demonstrating a greater depth and breadth of knowledge, a greater synthesis
of data, and increased complexity of skills and interventions, and

e. who has obtained a license as an Advanced Practice Registered Nurse in one of the following roles: Certified Registered Nurse Anesthetist, Certified Nurse-Midwife, Clinical Nurse Specialist, or Certified Nurse Practitioner.

Citation: OKLA. STAT. ANN. § 59-567.3a.5.

“Certified Nurse Practitioner” is an Advanced Practice Registered Nurse who performs in an expanded role in the delivery of health care:

a. consistent with advanced educational preparation as a Certified Nurse Practitioner in an area of specialty,

b. functions within the Certified Nurse Practitioner scope of practice for the selected area of specialization, and
c. is in accord with the standards for Certified Nurse Practitioners as identified by the certifying body and approved by the Board.

_Citation:_ OKLA. STAT. ANN. § 59-567.3a.6.

**Oregon**

“Nurse practitioner” (NP) means an advanced practice registered nurse who is certified by the Board to independently assume responsibility and accountability for the care of clients. The title nurse practitioner and population foci of practice shall not be used unless the individual is certified by the Board.

_Citation:_ OR. ADMIN. § R. 851-050-0000(24).

**Pennsylvania**

Certified Registered Nurse Practitioner—A professional nurse licensed in this Commonwealth who is certified by the Board in a specialty and who, while
functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with a physician licensed to practice in this Commonwealth and in accordance with the act and this subchapter. Nothing in this subchapter is to be deemed to limit or prohibit a professional nurse from engaging in those activities which constitute the practice of professional nursing as defined in section 2 of the act (63 P. S. § 212).

*Citation*: 49 P.A. CODE § 21.251.

**Rhode Island**

“Certified registered nurse practitioner” is an advanced practice nurse utilizing independent knowledge of physical assessment, diagnosis, and management of health care and illnesses. The practice includes prescriptive privileges. Certified nurse practitioners are members of the health care delivery system practicing
in areas including, but not limited to: family practice, pediatrics, adult health care, geriatrics, and women’s health care in primary, acute, long-term and critical care settings in health care facilities and the community. Certified nurse practitioners may be recognized as the primary care provider or acute-care provider of record.

Citation: R.I. GEn. LAWS § 5-34-3(3).

South Carolina

“Advanced Practice Registered Nurse” or “APRN” means a registered nurse who is prepared for an advanced practice registered nursing role by virtue of additional knowledge and skills gained through an advanced formal education program of nursing in a specialty area that is approved by the board. The categories of APRN are nurse practitioner, certified nurse-midwife, clinical nurse specialist, and certified registered nurse anesthetist. An advanced practice registered nurse shall hold a doctorate, a post-nursing master's certificate, or a minimum of a
master’s degree that includes advanced education composed of didactic and supervised clinical practice in a specific area of advanced practice registered nursing. In addition to those activities considered the practice of registered nursing, an APRN may perform delegated medical acts.

*Citation: 2 S.C. CODE ANN. § 40-33-20(5).*

“Nurse Practitioner” or “NP” means a registered nurse who has completed an advanced formal education program at the master’s level acceptable to the board, and who demonstrates advanced knowledge and skill in assessment and management of physical and psychosocial health, illness status of persons, families, and groups. Nurse practitioners who perform delegated medical acts must have a supervising physician or dentist who is readily available for consultation and shall
operate within the approved written protocols.

_Citation:_ 2 S.C. _Code_ Ann. § 40-33-20(41).

**South Dakota**

“Nurse practitioner,” a provider duly authorized under this chapter to practice the specialty of nurse practitioner as defined in 36-9A-12.

_Citation:_ S.D. _Codified Laws_ § 36-9A-1(5).

“Advanced practice registered nurse,” or “APRN,” a person licensed by the boards in the role of a certified nurse practitioner or a certified nurse midwife.

_Citation:_ S.D. _Codified Laws_ § 36-9A-1(8).

**Tennessee**

“Advanced practice nurse” means a registered nurse with a master’s degree or higher in a nursing specialty
and national specialty certification as a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist.

_Citation:_ TENN. CODE ANN. § 63-7-126(a).

### Texas

Advanced practice nurse—A registered nurse approved by the board to practice as an advanced practice nurse based on completing an advanced educational program acceptable to the board. The term includes a nurse practitioner, nurse-midwife, nurse anesthetist, and a clinical nurse specialist. The advanced practice nurse is prepared to practice in an expanded role to provide health care to individuals, families, and/or groups in a variety of settings including but not limited to homes, hospitals, institutions, offices, industry, schools, community agencies, public and private clinics, and private practice. The advanced practice nurse acts independently and/or in
collaboration with other health care professionals in the delivery of health care services.

_Citation: 22 TEX. ADMIN. CODE § 11.221.1(3)._ 

Advanced practice registered nurse (APRN)—As defined by §301.152, Occupations Code. The term includes an advanced nurse practitioner and advanced practice nurse.

_Citation: 22 TEX. ADMIN. CODE § 11.222.1(4)._ 

_Utah_ 

“Practice of advanced practice registered nursing” means the practice of nursing within the generally recognized scope and standards of advanced practice registered nursing as defined by rule and consistent with professionally recognized preparation and education standards of an advanced practice registered nurse by a person licensed under this chapter as an advanced practice registered
nurse. Advanced practice nursing includes:

- a. maintenance and promotion of health and prevention of disease;
- b. diagnosis, treatment, correction, consultation, and referral for common health problems; and
- c. prescription or administration of prescription drugs or devices, including:
  - i. local anesthesia;
  - ii. Schedule III-V controlled substances; and
  - iii. Schedule II controlled substances in accordance with Section 58-31b-803.

_Citation:_ UTAH CODE ANN. § 58-31b-102(14).

**Vermont**

“Advanced practice registered nurse” or “APRN” means a licensed registered nurse authorized to practice in this State who, because of
specialized education and experience, is licensed and authorized to perform acts of medical diagnosis and to prescribe medical, therapeutic, or corrective measures under administrative rules adopted by the Board.

*Citation*: VT. STAT. ANN. tit. 26-028-001, § 1572(4).

**Virginia**

“Licensed nurse practitioner” means an advanced practice registered nurse who has met the requirements for licensure as stated in Part II (18 VAC 90-30-60 et seq.) of this chapter.

*Citation*: 18 VA. CODE ANN. § 90-30-10.

**Washington**

“Advanced registered nurse practitioner (ARNP)” is a registered nurse (RN) as defined in RCW 18.79.050, 18.79.240, 18.79.250, and 18.79.400 who has obtained formal graduate education and national specialty certification through a
commission-approved certifying body in one or more of the designations described in WAC 246-840-302, and who is licensed as an ARNP as described in WAC 246-840-300. The designations include the following:

a. Nurse practitioner (NP);
b. Certified nurse midwife (CNM);
c. Certified registered nurse anesthetist (CRNA); and
d. Clinical nurse specialist (CNS).

_Citation:_ WASH. ADMIN. CODE § 246-840-010(3).

**West Virginia**

“Nurse practitioner” means a registered nurse qualified by virtue of his or her education and credentials and approved by the West Virginia Board of Examiners for registered professional nurses to practice as an advanced practice nurse independently or in a collaborative relationship with a physician.

_Citation:_ W. VA. CODE § 9-4B-1(c).
“Advanced nurse practitioner” means a registered nurse with substantial theoretical knowledge in a specialized area of nursing practice and proficient clinical utilization of the knowledge in implementing the nursing process, and who has met the further requirements of title 19, legislative rules for West Virginia board of examiners for registered professional nurses, series 7, who has a mutually agreed upon association in writing with a physician and has been selected by or assigned to the person and has primary responsibility for treatment and care of the person.

Citation: W. Va. Code § 16-30-3(c).

“Advanced practice registered nurse” means a registered nurse who has acquired advanced clinical knowledge and skills preparing him or her to provide direct and indirect care to patients as a certified nurse practitioner, certified nurse-midwife, certified registered nurse anesthetist, or certified nurse specialist, who has
completed a board-approved graduate-level education program and who has passed a board-approved national certification exam.

*Citation:* W. VA. CODE § 30-7-1(a).

**Wisconsin**

“Nurse practitioner” means a registered nurse licensed under Ch. 441 or in a party state, as defined in § 441.50(2)(j), whose practice of professional nursing under § 441.001(4) includes performance of delegated medical services under the supervision of a physician, dentist, or podiatrist.

*Citation:* WIS. STAT. § 255.06(1)(d).

**Wyoming**

“Advanced practice registered nurse (APRN)” means a nurse who:

A. May prescribe, administer, dispense, or provide nonprescriptive and prescriptive medications including
prepackaged medications, except schedule I drugs as defined in W.S. 35-7-1013 and 35-7-1014;

B. Has responsibility for the direct care and management of patients and clients in relation to their human needs, disease states and therapeutic and technological interventions;

C. Has a master’s degree in nursing, or an advanced practice registered nurse specialty or has completed an accredited advanced practice registered nurse educational program prior to January 1, 1999; and

D. Has completed an advanced program of study in a specialty area in an accredited nursing program, has taken and passed a national certification examination in the same area and has been granted recognition by the board to practice as an APRN.
Citation: WYO. STAT. ANN. § 33-21-120(a)(i).
Appendix 1-B: State-by-State Titles for Nurse Practitioners

**ALABAMA:** Certified Registered Nurse Practitioner (CRNP)

**ALASKA:** Advanced Nurse Practitioner (ANP)

**ARIZONA:** Registered Nurse Practitioner (RNP)

**ARKANSAS:** Certified Nurse Practitioner (CNP) or Advanced Practice Registered Nurse (APRN)

**CALIFORNIA:** Nurse Practitioner (NP)

**COLORADO:** Nurse Practitioner (NP) or Advanced Practice Nurse (APN)

**CONNECTICUT:** Advanced Practice Registered Nurse (APRN) or Certified Nurse Practitioner (CNP)

**DELAWARE:** Advanced Practice Nurse (APN), Nurse Practitioner (NP), or Advanced Practice Registered Nurse (APRN)
DISTRICT OF COLUMBIA: Advanced Practice Registered Nurse (APRN) or Nurse Practitioner (NP)

FLORIDA: Advanced Registered Nurse Practitioner (ARNP)

GEORGIA: Advanced Practice Registered Nurse (APRN) or Nurse Practitioner (NP)

HAWAII: Advanced Practice Registered Nurse (APRN)

IDAHO: Advanced Practice Registered Nurse (APRN) or Nurse Practitioner (NP)

ILLINOIS: Advanced Practice Nurse (APN)

INDIANA: Advanced Practice Nurse (APN) or Nurse Practitioner (NP)

IOWA: Advanced Registered Nurse Practitioner (ARNP) or Certified Nurse Practitioner (CNP)

KANSAS: Advanced Practice Registered Nurse (APRN)

KENTUCKY: Advanced Practice Registered Nurse (APRN)

LOUISIANA: Advanced Practice Registered Nurse (APRN)
MAINE: Advanced Practice Registered Nurse (APRN) or Certified Nurse Practitioner (CNP)

MARYLAND: Certified Registered Nurse Practitioner (CRNP)

MASSACHUSETTS: Advanced Practice Registered Nurse (APRN) or Certified Nurse Practitioner (CNP)

MICHIGAN: Certified Nurse Practitioner (CNP)

MINNESOTA: Advanced Practice Registered Nurse Practitioner (APRN) or Nurse Practitioner (NP)

MISSISSIPPI: Advanced Practice Registered Nurse (APRN) or Certified Nurse Practitioner (CNP)

MISSOURI: Advanced Practice Registered Nurse (APRN)

MONTANA: Advanced Practice Registered Nurse (APRN)

NEBRASKA: Nurse Practitioner (NP) or Advanced Practice Registered Nurse (APRN)

NEVADA: Advanced Practice Registered Nurse (APRN)
**NEW HAMPSHIRE:** Advanced Practice Registered Nurse (APRN)

**NEW JERSEY:** Advanced Practice Nurse (APN)

**NEW MEXICO:** Certified Nurse Practitioner (CNP)

**NEW YORK:** Nurse Practitioner (NP)

**NORTH CAROLINA:** Advanced Practice Registered Nurse (APRN) or Nurse Practitioner (NP)

**NORTH DAKOTA:** Advanced Practice Registered Nurse (APRN) or Nurse Practitioner (NP)

**OHIO:** Certified Nurse Practitioner (CNP) or Advanced Practice Registered Nurse (APRN)

**OKLAHOMA:** Advanced Practice Registered Nurse (APRN) or Certified Nurse Practitioner (CNP)

**OREGON:** Nurse Practitioner (NP) or Advanced Practice Registered Nurse (APRN)

**Pennsylvania:** Certified Registered Nurse Practitioner (CRNP)
RHODE ISLAND: Certified Registered Nurse Practitioner (RNP) or Certified Nurse Practitioner (CNP)

SOUTH CAROLINA: Advanced Practice Registered Nurse (APRN) or Nurse Practitioner (NP)

SOUTH DAKOTA: Advanced Practice Registered Nurse (APRN), Certified Nurse Practitioner (CNP), or Nurse Practitioner (NP)

TENNESSEE: Advanced Practice Nurse (APN) or Certified Nurse Practitioner (CNP)

TEXAS: Advanced Practice Registered Nurse (APRN), Advanced Practice Nurse (APN), or Advanced Nurse Practitioner (ANP)

UTAH: Advanced Practice Registered Nurse (APRN)

VERMONT: Advanced Practice Registered Nurse (APRN)

VIRGINIA: Advanced Practice Registered Nurse (APRN) or Licensed Nurse Practitioner (LNP)

WASHINGTON: Advanced Registered Nurse Practitioner (ARNP) or Nurse Practitioner (NP)
WEST VIRGINIA: Advanced Nurse Practitioner (ANP), Advanced Practice Registered Nurse (APRN), or Nurse Practitioner (NP)

WISCONSIN: Nurse Practitioner (NP)

WYOMING: Advanced Practice Registered Nurse (APRN)
Chapter 2: Legal Nurse Practitioner Scope of Practice

Having an adequate legal description of nurse practitioner (NP) scope of practice according to state law is important for the following reasons:

1. To allow NPs to perform at their level of education and training
2. To avoid any charges of practicing medicine without a license
3. To avoid imputation of liability for medical malpractice to someone other than the NP, usually a physician
4. To place accountability for both benefits and harm to patients squarely on the NP
5. To provide a basis for inclusion of NPs in the legal definition of primary care and/or specialty or acute care providers, which is necessary for admission to provider panels and hospital medical staff
6. To establish that the NP is a professional entity, not just a “nonphysician,” a “physician extender,” or whatever an agency, employer, or delegating physician decides an NP is

7. To get reimbursement for physician services, when provided by an NP

State law is the most powerful source of authority for professional practice. However, federal agencies and private businesses may have policies on NP scope of practice, and professional societies may have accepted certain tasks, functions, activities, and decisions as part of NP scope of practice.

**Professional Association Definition of Scope of Practice**

Some associations define the scope of practice for NPs in general or for individual NPs. For example, the American Academy of Nurse Practitioners’ statement on scope of practice says:

Nurse practitioners (NPs) are licensed, independent practitioners who practice in ambulatory, acute and long-term care as primary and/or specialty care providers. Nurse practitioners assess, diagnose, treat, and manage acute episodic and chronic illnesses. NPs
are experts in health promotion and disease prevention. They order, conduct, supervise, and interpret diagnostic and laboratory tests, prescribe pharmacological agents and non-pharmacologic therapies, as well as teach and counsel patients, among other services. . . .

**Statutory Versus Regulatory NP Scope of Practice**

Some states define scope of practice in statutes enacted by the state legislature. In other states, the legislature gives the board of nursing the authority to define the NP scope of practice. Either way is enforceable, and regulations carry the same force of law as statutes.

Some states describe scope of practice specifically, and some define it generally. State statutes describing NP scope of practice fall into six categories:

1. Scope of practice is clearly defined by statute.
2. Scope of practice is clearly defined by regulation.
3. Scope of practice is vaguely defined by statute.
4. Scope of practice is not defined.
5. Scope of practice is defined by exception from a state law prohibiting the practice of medicine without a license.
6. Scope of practice is defined by the individual physician, who may delegate to an NP by law.

The first category is the most secure for the NP.

At a time when NPs are viewed by some physicians as competitors, the first response to competitive pressures is often for physicians to point to state law and ask for strict interpretation. For example, physicians’ associations may counter NPs’ efforts to be designated as primary care providers (PCPs) for managed-care organizations or a patient’s “medical home” by claiming that state law does not explicitly authorize NPs to perform the necessary functions. Then, only NPs in states where the NP scope of practice is clearly defined as including medical diagnosis and treatment, prescription of medication, and oversight of comprehensive healthcare services for patients will have legal grounds for arguing that NPs should be admitted to provider panels as PCPs or designated a “medical home.”
A vaguely worded nurse practice act that states, for example, that the NP scope of practice includes “acts of advanced nursing practice” will not provide sound legal basis for arguments that NPs should be admitted to managed-care provider panels or receive fees for providing physician services. It is difficult to argue to managed-care executives, state administrators, and legislators that “acts of nursing practice” are the acts necessary to perform physician services.

**Physician Challenges to NP Scope of Practice**

An example of a physician challenge to NP scope of practice is a 1984 Missouri court case, *Sermchief v. Gonzales* [660 S.W.2d 683 (Mo. 1984)]. That case, which the NPs won only after it went to the state’s supreme court, could be repeated in other states today where state law is not specific enough about the authority of NPs to diagnose and treat.

In *Sermchief*, two obstetric-gynecologic NPs were working in a family planning clinic under written protocols with the clinic’s physicians. The NPs were taking histories, performing physical examinations, treating minor illnesses, and prescribing contraceptives. There was no specific charge of malpractice, but rather the Missouri Board of
Medicine charged that the NPs were practicing medicine without a license.

The lower court agreed and found that the NPs were practicing medicine without a license. However, the Missouri Supreme Court, after analyzing the nurse practice act, noted that the legislature had deleted a requirement that a physician directly supervise nursing functions and decided that by that deletion the legislature had intended to broaden the scope of nursing.

The NPs eventually prevailed in the case, but that will not necessarily help NPs in other states if there is no express statutory authority for NPs’ medical functions. NPs need a clear statutory definition of the scope of practice that includes medical diagnoses and treatment and prescriptive authority.

**Need for Clarity of Scope of Practice**

Some state laws describe scope of practice succinctly and others go into great detail. Longer is not necessarily better, and vague language should be avoided. Consider Oklahoma’s statute on NP scope of practice.
“Certified Nurse Practitioner” is an Advanced Practice Registered Nurse who performs in an expanded role in the delivery of health care:

a. consistent with advanced educational preparation as a Certified Nurse Practitioner in an area of specialty,

b. functions within the Certified Nurse Practitioner scope of practice for the selected area of specialization, and

c. is in accord with the standards for Certified Nurse Practitioners as identified by the certifying body and approved by the Board.

A Certified Nurse Practitioner shall be eligible, in accordance with the scope of practice of the Certified Nurse Practitioner, to obtain recognition as authorized by the Board to prescribe, as defined by the rules promulgated by the Board pursuant to this section and subject to the medical direction of a supervising physician. This
authorization shall not include dispensing drugs, but shall not preclude, subject to federal regulations, the receipt of, the signing for, or the dispensing of professional samples to patients.

Citation: OKLA. STAT. ANN. tit. 59, § 567.3a(6).

Under Oklahoma’s statutory definition of NP scope of practice, an NP can prescribe, but it is unclear what else an NP can do. To prove that the NP can make medical diagnoses, the NP would need to produce transcripts and course descriptions, as well as information from the certifying body on their view of scope of practice. Oklahoma’s Administrative Code provides a detailed description of NP scope of practice, however. The Oklahoma Administrative Code states the following:

The Certified Nurse Practitioner’s scope of practice includes the full scope of nursing practice and practice in an expanded role as follows:

1. The Certified Nurse Practitioner (CNP) provides comprehensive
health care to clients across the life span.

2. The CNP is responsible and accountable for the continuous and comprehensive management of a broad range of health services, which include, but are not limited to:
   A. promotion and maintenance of health;
   B. prevention of illness and disability;
   C. diagnosis and prescription of medications, treatments, and devices for acute and chronic conditions and diseases;
   D. management of health care during acute and chronic phases of illness;
   E. guidance and counseling services;
   F. consultation and/or collaboration with other health care providers and community resources;
G. referral to other health care providers and community resources.

*Citation:* OKLA. ADMIN. CODE § 485:10–15.6(b).

An example of a comprehensive description of scope of practice is Pennsylvania’s law:

When acting in collaboration with a physician as set forth in a collaborative agreement and within the CRNP’s specialty, a CRNP may:

1. Perform comprehensive assessments of patients and establish medical diagnoses.
2. Order, perform and supervise diagnostic tests for patients and, to the extent the interpretation of diagnostic tests is within the scope of the CRNP’s specialty and consistent with the collaborative agreement, may interpret diagnostic tests.
3. Initiate referrals to and consultations with other
licensed professional health care providers, and consult with other licensed professional health care providers at their request.

4. Develop and implement treatment plans, including issuing orders to implement treatment plans. However, only a CRNP with current prescriptive authority approval may develop and implement treatment plans for pharmaceutical treatments.

5. Complete admission and discharge summaries.

6. Order blood and blood components for patients.

7. Order dietary plans for patients.

8. Order home health and hospice care.


10. Issue oral orders to the extent permitted by the health care facilities’ by-laws, rules, regulations or administrative policies and guidelines.
11. Make physical therapy and dietitian referrals.
12. Make respiratory and occupational therapy referrals.
13. Perform disability assessments for the program providing temporary assistance to needy families (TANF).
15. Perform and sign the initial assessment of methadone treatment evaluations, provided that any order for methadone treatment shall be made only by a physician.

_Citation_: 49 P.A. code § 21.251.

See _Exhibit 2-1_ for a breakdown of elements of NP practice found in various state laws. See _Appendix 2-A_ for the law of each of the states regarding NP scope of practice.

### Exhibit 2-1 Specific Functions Included in States’ Definitions of NP Scope of Practice

<table>
<thead>
<tr>
<th>Diagnose</th>
<th>KS</th>
<th>NC</th>
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NP Scope of Practice Compared with Registered Nurse Scope of Practice

NP scope of practice usually includes medical diagnosis and treatment, whereas registered nurse (RN) scope of practice usually includes “nursing diagnosis” and “nursing interventions” or “nursing treatments.”

Compare Oregon’s scope of practice for an RN to Oregon’s scope of practice for an NP. Oregon’s law on scope of practice for an RN states:

The Board recognizes that the scope of practice for the registered nurse encompasses a variety of roles, including, but not limited to:

a. Provision of client care;
b. Supervision of others in the provision of care;
c. Development and implementation of health care policy;
d. Consultation in the practice of nursing;
e. Nursing administration;
f. Nursing education;

h. Nursing research;

i. Teaching health care providers and prospective health care providers;

j. Specialization in advanced practice;

k. Nursing informatics.

_Citation:_ OR. ADMIN. § R. 851-045-0060.

Oregon’s board of nursing has elegantly defined the NP scope of practice as follows:

3. The nurse practitioner provides holistic health care to individuals, families, and groups across the life span in a variety of settings, including hospitals, long-term care facilities, and community-based settings.

4. Within his or her specialty, the nurse practitioner is responsible for managing health problems encountered by the client and is accountable for health
outcomes. This process includes:
   a. Assessment;
   b. Diagnosis;
   c. Development of a plan;
   d. Intervention;
   e. Evaluation.

5. The nurse practitioner is independently responsible and accountable for the continuous and comprehensive management of a broad range of health care, which may include:
   a. Promotion and maintenance of health;
   b. Prevention of illness and disability;
   c. Assessment of clients, synthesis and analysis of data, and application of nursing principles and therapeutic modalities;
   d. Management of health care during acute and chronic phases of illness;
   e. Admission of his/her clients to hospitals and
long-term care facilities
and management of client
care in these facilities;
f. Counseling;
g. Consultation and/or
collaboration with other
care providers and
community resources;
h. Referral to other
healthcare providers and
community resources;
i. Management and
coordination of care;
j. Use of research skills;
k. Diagnosis of
health/illness status;
l. Prescribing, dispensing,
and administration of
therapeutic devices and
measures, including
legend drugs and
controlled substances as
provided in Division 56 of
the Oregon Nurse
Practice Act, consistent
with the definition of the
practitioner’s specialty
category and scope of practice.

6. The nurse practitioner’s scope of practice includes teaching the theory and practice of advanced practice nursing.

7. The nurse practitioner is responsible for recognizing limits of knowledge and experience, and for resolving situations beyond his/her nurse practitioner expertise by consulting with or referring clients to other healthcare providers.

8. The nurse practitioner will only provide healthcare services within the nurse practitioner’s scope of practice for which he/she is educationally prepared and for which competency has been established and maintained. Educational preparation includes academic course work, workshops or seminars, provided both theory and clinical experience are included.
In California, NP scope of practice is defined as that of an RN:

The nurse practitioner shall function within the scope of practice as specified in the Nursing Practice Act and as it applies to all registered nurses.

An NP or RN gets the authority to perform medical acts through standardized procedures developed with physicians. Here is a statement from the California Board of Registered Nursing website about NP scope of practice:

The NP does not have an additional scope of practice beyond the usual RN scope and must rely on standardized procedures for authorization to perform overlapping medical functions (CCR Section 1485). Section 2725 of the Nursing Practice Act (NPA)
provides authority for nursing functions that are also essential to providing primary health care which do not require standardized procedures. Examples include physical and mental assessment, disease prevention and restorative measures, performance of skin tests and immunization techniques, and withdrawal of blood, as well as authority to initiate emergency procedures.

Nurse practitioners frequently ask if they really need standardized procedures. The answer is that they do when performing overlapping medical functions. Standardized procedures are the legal authority to exceed the usual scope of RN practice. Without standardized procedures the NP is legally very vulnerable, regardless of having been certified as a RN, who has acquired additional skills as a certified nurse practitioner.²

In general, NPs may make medical diagnoses and initiate and perform medical treatments, whereas
RNs may not. RNs may make nursing diagnoses, carry out physician or NP orders, and perform nursing treatments, as well as many other functions. Ideally, NPs have clear authority under state law to perform comprehensive evaluations; make medical diagnoses; order tests; initiate and perform medical therapies, including the prescribing of medication; and admit patients to hospitals.

**NP and Physician Scope of Practice Compared**

When NP scope of practice is defined to include medical diagnosis, medical treatment, prescriptive authority, and admission of patients to hospitals, as in Oregon law, there is significant overlap between NP and physician scope of practice. However, in most states, medical scope of practice is defined more broadly than the scope of practice for any other healthcare professional. Consider Mississippi’s definition of the practice of medicine:

> The practice of medicine shall mean to suggest, recommend, prescribe, or direct for the use of any person, any drug, medicine, appliance, or other agency, whether material or not material, for the cure, relief, or palliation of any ailment or disease of
the mind or body, or for the cure or relief of any wound or fracture or other bodily injury or deformity, or the practice of obstetrics or midwifery, after having received, or with the intent of receiving therefore, either directly or indirectly, any bonus, gift, profit, or compensation; provided, that nothing in this section shall apply to females engaged solely in the practice of midwifery.

Citation: MISS. CODE ANN. § 73-25-33.

The liberal use of the word “any” differentiates the physician scope of practice from the NP scope of practice. There are no laws that authorize as wide a scope of practice for NPs as the Mississippi law authorizes for physician practice.

Can an NP Work Outside the NP’s Certification?
Consider these scenarios:

1. A new family NP (FNP) is offered a job in a neurology practice. Part of her time is to be spent in the office and about half of her time
is to be spent in a hospital, evaluating patients who may be having acute stroke.

2. An experienced FNP is offered a job in a hospital, to care for patients in nonmonitored beds.

3. An experienced FNP is offered a job in a hospital, to care for patients in nonmonitored and monitored beds.

4. An acute care NP is offered a job at a med-spa, performing Botox injections.

5. A women’s health NP is offered a job in a psychiatrist’s office, performing medication adjustments.

All of these scenarios are true stories. Not all of the jobs offered are appropriate for the NP described. Employers don’t necessarily know what is appropriate practice for an NP. It is the NP’s responsibility to perform only the services and care the NP is educated and certified to provide.

The answer to whether the NP in each of these scenarios should take the job can be found by querying the Board of Nursing in the state where the NP is certified and will practice. In the author’s opinion, the answers to whether the NP in each scenario can or should take the job follow:
1. No. The acute care part of the job is appropriate only for an NP certified in acute care.

2. Yes, though FNP certification is not optimal for hospital practice. The key is that the patients the FNP will manage are not acutely ill enough to be in monitored beds. And at least one board of nursing presented with this scenario approved of the role for the FNP. However, if something goes wrong with an NP’s patient and the hospital and NP are sued, the plaintiff may argue that the NP was not qualified. The FNP should become certified in acute care as soon as possible.

3. No. Only an NP certified in acute care should care for patients in monitored beds.

4. Yes, but at least one Board of Nursing said no. The Board said Botox injection is a primary care function. The Board of Nursing gets the final say.

5. No. The women’s health NP is not certified nor qualified to adjust psychiatric medications. Any challenge, whether a lawsuit or complaint to the Board of Nursing, is not likely to go well.

Controversy About FNPs Working in Hospitals
When hospitals first hired NPs, there was no acute care certification, so FNPs were hired. Some of those FNPs are still working at hospitals and have been doing so for more than 20 years. However, now there is acute care NP education and certification. So being an FNP, where preparation focuses on primary care, is not the optimal match for inpatient, emergency department (ED), or intensive care unit (ICU) practice.

The Board of Nursing for each state is the final authority on whether it is within the scope of practice of an FNP to work in acute care and/or intensive care. Boards differ in their policies. One Board said that an FNP (or another type of NP not certified specifically in acute care) may not care for patients on monitors. That would significantly curtail the usefulness of an NP working in an ED or ICU.

Some Boards take no stand on this issue. Other Boards provide decision-making tools to use to determine whether a function or set of functions are appropriately performed by an individual nurse. Questions to be answered include:

- Did I complete a program that prepared me to see this population of patients?
- Did this program include supervised clinical and didactic training focusing on this population?
- Did I complete a program that prepared me for subspecialization? If so, is the patient in question in that category?
- Do I have the knowledge to differentially diagnose and manage the conditions for which I am seeing this patient?
- What are the clinical competence/skills required to treat this condition?
- Have I been trained to differentially diagnose in this type of patient?
- Did this training include clinical and didactic training?
- How have I achieved and demonstrated competence?
- How have I maintained competence?
- What is the standard of a practitioner in this field, and do I meet it?
- Do I meet these standards on a limited or broad basis?
- Have I completed a specialty preceptorship, fellowship, or internship that qualifies me beyond my basic educational training? What are the potential consequences of accepting treatment responsibility for this patient?
- Am I prepared to accept and manage the consequences of my diagnosis and treatment, or
do I have a formally established relationship with a provider who is so trained and immediately available?
- If I am not the primary care provider, will my provision of care be shared with this person?
- Is the safety of the patient at acute risk if I do not act?
- Will the safety of the patient be compromised if I do act?\

If something goes wrong and the FNP working in acute care is sued, the first thing the plaintiff’s attorney will ask is, “What qualifies you to provide emergency services (or critical care, acute care, or specialty care)?” An NP who is certified in acute care and/or emergency care can point to the certification. An NP certified as an FNP is going to be in a weak position, because FNP programs do not prepare NPs to provide services in acute care.

FNPs who have been practicing in hospitals, EDs, or ICUs since 1990 will be in a better position to defend their competence and lack of the appropriate credential than newer FNPs. Critical care experience as an RN may be a practical asset, but it does not substitute for advanced practice didactic learning, supervised clinical practice, evaluation by a preceptor, and successful completion of a certification examination. Given that acute care
certification has been available for at least 20 years, any new NP would be wise to obtain that education and certification, if working in the ICU and/or ED setting is the goal. Only if the state Board of Nursing gives the go-ahead for FNPs to practice in EDs and ICUs should an FNP without additional certification feel comfortable practicing in acute and critical care.

An Individual NP’s Portfolio
Individual NPs may want to develop portfolios—compilations of documentation of the NP’s education, training, and experience. The portfolio often is a binder containing pages, which may be removed and copied as needed.

There are at least three good reasons to keep a portfolio. First, in many states, NPs must submit to the Board of Nursing a written agreement stating the services the NP is authorized to perform. NPs may want to perform procedures, such as colposcopy or suturing. Boards may require NPs to document that they are qualified to perform such procedures. Qualifications might include formal course work, informal course work, or formal or informal one-to-one preceptorship experience. NPs can find it difficult to document such training, especially if the NP learned how to perform a procedure years ago from a physician while on the job. If NPs document
the teaching at the time it is done, through a letter or form signed and dated by the instructor, the NP can produce the document as needed many years later, assuming the NP keeps such documents in a safe place—in the portfolio.

Second, some states’ laws defer to scope of practice statements adopted by professional organizations. For example, Texas law states the following:

The advanced practice nurse provides a broad range of health services, the scope of which shall be based upon educational preparation, continued advanced practice experience, and the accepted scope of professional practice of the particular specialty area. Advanced practice nurses practice in a variety of settings and, according to their practice specialties and roles, they provide a broad range of healthcare services to a variety of patient populations.

1. The scope of practice of particular specialty areas shall be defined by national
professional specialty organizations or advanced practice nursing organizations recognized by the Board. The advanced practice nurse may perform only those functions which are within that scope of practice and which are consistent with the Nursing Practice Act, Board rules, and other laws and regulations of the State of Texas.

*Citation: TEx. ADMIN. CODE § 221.12.*

NPs living in states with laws similar to that of Texas should have the scope and standards of practice established by the national organization representing the NP’s specialty in their portfolios.

For example, if an NP in Texas is certified by the American Academy of Nurse Practitioners (AANP), the NP should keep in his or her portfolio a one-page document from the AANP website titled *Scope of Practice for Nurse Practitioners*. The document states that NPs provide nursing and medical services, diagnose and manage acute episodic and
chronic illness, order diagnostic tests, prescribe, and counsel patients and families.

Third, some nurses are using their portfolios in place of résumé when interviewing for jobs. A portfolio could include the following:

- Statement of career goals
- Description of special interests or abilities
- Description of special projects conducted by the individual
- Articles or reports written by the individual
- Articles written about the individual
- Brochures from previous practices
- Testimonials or letters of appreciation from patients
- Letters of reference from former employers or coworkers
- Awards, honors, or distinction earned by the individual
- Transcripts
- Diplomas
- Certificates of certification as advanced practice nurse
- Nursing and advanced practice nursing (APN) license
- Photo of the individual
- Certificates of continuing education or training
Letters of recommendation
- Letters, forms, or photographs documenting one-on-one training
- List of former jobs or projects
- National Provider Identifier and any other provider numbers needed for reimbursement
- Drug Enforcement Agency number and state controlled substances prescriber number
- Certificate of professional liability insurance
- Copy of state law addressing NP scope of practice, prescribing, qualifications, and physician collaboration requirements, if any
- Previous written agreements if state law requires physician collaboration
- Outcomes data if the NP or an employer has tracked the NP’s outcomes
- Data on performance measures if the NP has participated in one of Medicare’s quality reporting programs or other quality measurement programs
- Productivity data if the NP or an employer has tracked visits, revenues, and collections
- Patient satisfaction data if the NP or an employer has tracked patient satisfaction

Finally, it saves time if one keeps the documents related to one’s professional practice in one place.

**Mandated Physician Involvement**
with NP Practice
In some states, there is no legal requirement for physician involvement in NP practice. However, in the majority of states, there is some legal requirement for physician involvement. That involvement may be “supervision,” “collaboration,” or some other form. It may be limited to situations where the NP is prescribing medications, or it may be required for all advanced practice.

See Exhibit 2-2 for a chart listing requirements of physician involvement by state. For text of state laws regarding physician involvement, see Appendix 2-B.

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Some states require that NPs practice using written protocols. Some states require a written agreement between the NP and the physician that states how the physician will participate in NP practice, what medications the NP may prescribe, what procedures an NP may perform, how often a physician will review NP documentation, and under what circumstances an NP must contact a physician. A protocol is a written instrument that guides the NP in collecting data from the patient and recommends specific action based upon the collected data. It consists of mutually agreed on medical guidelines between the physician and the NP that define their
individual and shared responsibilities. The protocol is considered a standard because it provides a guideline for a minimum level of safe practice in specific situations. Exhibit 2-3 is an example of a protocol.

**Exhibit 2-3 Urinary Tract Infection Protocol: Initial Visit**

I. RATIONALE

This protocol will assist in the differentiation between pyelonephritis and urinary tract symptoms sufficiently to eradicate the symptoms per se rather than an attempt to eradicate any bacteriuria that may or may not be present. The design of the protocol for urinary tract infection (UTI) encompasses these principles.

II. SYMPTOMS

A. CYSTITIS

1. Female patients
   Order a STAT clean catch urinalysis (UA) for female patients with any of the following symptoms:
   a. Dysuria,
   b. Frequency,
c. Urgency,
d. Inability to empty bladder completely.

2. Male patients
Male patients with any of the above symptoms should be seen by a physician, not by an NP, unless they have a urethral discharge (possible venereal disease [VD]—follow VD protocol).

B. PYELONEPHRITIS
1. In addition to the above symptoms, patients with pyelonephritis may have:
   a. Fever greater than 100.0°F, or
   b. Flank pains, or
   c. Chills, or
   d. Nausea, vomiting, or abdominal pain.
2. Continue with protocol through the physical exam with these patients, but then consult supervising physician before deciding on treatment.

III. HISTORY

A. Consult supervising physician if patient has:
   1. A history of kidney problems, or
   2. Is currently pregnant. To ascertain this, always ask for last menstrual period date and record for all female patients.
   3. Diabetes or insulin.
   4. Three or more UTIs in past 12 months.

B. Continue with UTI protocol, but also refer patient to gynecology practitioner if history of:
   1. Vaginal discharge, or
   2. Perineal inflammation.
IV. PHYSICAL EXAM
A. Perform the following examinations:
   1. Abdominal
   2. Costovertebral angle (CVA) tenderness
   3. Temperature

B. Consult supervising physician if findings of:
   1. Fever greater than 100.0°F, or
   2. CVA tenderness.

V. LAB TESTS INITIAL URINALYSIS
A. Consult supervising physician if:
   1. Casts
   2. Red blood cells (RBCs) or protein are positive (with associated white blood cell [WBC] abnormality).

B. If UA shows 10 or more WBCs/hpf and patient is symptomatic, give patient antibiotic prescription as
described in the treatment section.

C. If UA revealed 0–10 WBCs, review symptoms. If the symptoms are definite and very severe, treat with antibiotics; if symptoms are vague and poorly defined, then give patient symptomatic treatment as described in the treatment section and consider referral to gynecology for pelvic.

D. Should the initial UA be “positive”: (defined in guidelines below), then give patient a repeat UA slip for the abnormality found with instructions to have the UA 1 week following completion of treatment.

Positive UA findings are defined as:

- Casts: any except occasional hyaline or rare granular
- RBC > 3 (if not menstruating) and WBC < 5
- Protein > trace and WBC < 5
VI. TREATMENT ANTIBACTERIAL TREATMENT
To be given if initial UA reveals 10 or more WBC/hpf, or in any case where symptoms are severe, even if UA revealed WBC/hpf.
   A. Prescribe appropriate antibiotic drug (see below).
   B. Instruct patient to call in if symptoms do not subside within 72 hours. If patient does call back, give treatment failure instructions.

SYMPTOMATIC TREATMENT
To be given only if initial UA reveals 10 WBC/hpf and patient has minimal or uncertain symptoms. Consider gynecology referral for pelvic.
   A. Prescribe either Propantheline 15 mg #20 sig: 1-2 QID prn or Belladonna with Pb tabs #15, sig: 1 tab QID prn.
   B. Instruct patient to call in if symptoms persist beyond 72 hours or if symptoms worsen at any time.
VII. REPEAT URINALYSIS

A. Consult supervising physician if UA shows casts.

B. If repeat UA conforms abnormality (protein and/or RBC as listed below) refer to proteinuria and/or hematuria protocols.

Positive UA findings are defined as:

- Casts: any, except occasional hyaline or rare granular
- RBC > 3 (if not menstruating)
- and WBC < 5
- Protein > trace and WBC < 5

UTI PROTOCOL: ANTIBIOTIC TREATMENT

A. If organism found in patient’s urine is not listed in the table below, consult supervising physician for treatment.

B. If this is the first antibiotic course (initial visit), assume *E. coli* and use the first listed drug to which patient is not allergic listed for *E. coli* in the Antibiotic Prescription Table following.

C. If this is a second antibiotic course (treatment failure), go to the first drug
for the organism listed that is not the same as that previously used and to which the patient is not allergic. If the patient is allergic to all drugs listed, consult supervising physician for treatment.

D. Prescribe according to the Antibiotic Prescription Table that follows:
   1. If symptoms have been present within the past 48 hours, use 1-dose treatment.
   2. If symptoms have been present longer than 48 hours, use 5-day treatment.
   3. If symptoms persist after treatment with first drug, repeat UA and culture and consult supervising physician.

**UTI PROTOCOL: TREATMENT FAILURE**

If the patient calls in with persisted or recurrent symptoms after the first course of antibiotic treatment, obtain a clean catch urine specimen for UA and culture and sensitivity.

If the UA is negative, wait for the culture results before treating. If the UA is positive,
treat with the next drug listed on the Antibiotic Prescription Table and review treatment choice when the culture and sensitivity results are available.

If culture is positive and patient’s symptoms are improving, stay with the same antibiotic. If not responding after 3 days, switch to a new antibiotic based on culture sensitivity.

Adapted from protocol developed by:

___________________________________________________________________, NP

___________________________________________________________________, MD

(List names of nurse practitioners and physicians who developed the standardized procedure, including the protocol section.)

ANTIBIOTIC PRESCRIPTION TABLE

<table>
<thead>
<tr>
<th>Organism</th>
<th>Drug</th>
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<tbody>
<tr>
<td><em>E. coli</em>, <em>Proteus mirabilis</em></td>
<td>Septra DS, Amoxicillin</td>
</tr>
<tr>
<td></td>
<td>Macrodantin, Keflex</td>
</tr>
<tr>
<td><em>Aerobacter</em>, <em>Klebsiella</em></td>
<td>Septra DS, Macrodantin</td>
</tr>
<tr>
<td></td>
<td>Keflex, Ciprofloxacin</td>
</tr>
</tbody>
</table>
| **Enterococcus** | Ampicillin  
*Consult MD if allergic |
|------------------|----------------------------------|
| **Pseudomonas**  | Ciprofloxacin  
(Usually not seen in out-patient setting) |

### Dosages

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage Information</th>
</tr>
</thead>
</table>
| Septra DS        | #3 PO at once  
or 1 bid × 5 days                                      |
| Amoxicillin      | 500 mg 3 gms PO at once  
or 250 mg 1 tid × 5 days                               |
| Macrodantin      | 100 mg qid × 5 days                                      |
| Keflex           | 250 mg qid × 5 days                                      |
| Ciprofloxacin    | 250 mg qid × 5 days                                      |


### Notes


Appendix 2-A Scope of Practice

In some states scope of practice is specified by statute; in other states it is specified by regulation. Both statutes and regulations carry the same legal weight. Statutes are laws made by the legislature; they are also changed by a vote of the legislature. Regulations are executive agency-made law; they can be changed by the agency or overridden by statute.

The following are excerpts from state law. For the complete language, see each state’s Nurse Practice Act, usually available online through the state’s Board of Nursing website.

**Alabama**

Practice as a certified registered nurse practitioner (CRNP) means the performance of nursing skills by a registered nurse who has demonstrated by certification that he or she has advanced knowledge and skills in the delivery of nursing services within a health care system that provides for consultation,
collaborative management, or referral as indicated by the health status of the client.

*Citation: A LA. CODE § 34-21-81(4a).*

Functions and activities of certified registered nurse practitioners.

1. The certified registered nurse practitioner is responsible and accountable for the continuous and comprehensive management of a broad range of health services for which the certified registered nurse practitioner is educationally prepared and for which competency is maintained, with physician collaboration as described in these rules. These services include but are not restricted to the following:
   a. Evaluate current health status and risk factors of individuals based on comprehensive health history and comprehensive physical examinations and assessments.
   b. Formulate a working diagnosis, develop and implement a treatment plan, and evaluate and modify therapeutic regimens to promote positive patient outcomes.
c. Prescribe, administer and provide therapeutic measures, tests, procedures, and drugs.
d. Counsel, teach and assist individuals and families to assume responsibility for self-care in prevention of illness, health maintenance, and health restoration.
e. Consult with and refer to other health care providers as appropriate.

2. A standard protocol approved by the Board of Nursing and State Board of Medical Examiners shall address permissible functions and activities specific to the advanced practice of the certified registered nurse practitioner.

3. A certified registered nurse practitioner may, after the successful completion of an organized program of study and supervised clinical practice, carry out functions beyond the nurse practitioner educational preparation provided the functions are approved by the Board of Nursing as being within the legal scope of practice for a certified registered nurse practitioner. Such functions shall be submitted to the Joint Committee for
consideration for inclusion on the standard protocol.

4. Requests for additional functions to be added to the protocol may be submitted to the Joint Committee for consideration.

5. A certified registered nurse practitioner may write admission orders for inpatients as directed by the physician and subsequent orders in accordance with established protocols and institutional policies.

Citation: ALA. ADMIN. CODE r. 610-X-5-.11.

Alaska
The board recognizes advanced and specialized acts of nursing practice as those described in the scope of practice statements for nurse practitioners certified by national certification bodies recognized by the board.

Citation: 12 ALASKA ADMIN. CODE § 44.430.

Authority: AS 08.68.100(a).

Arizona
A. An RNP shall refer a patient to a physician or another health care provider if the referral will protect the health and welfare of the patient
and consult with a physician and other health care providers if a situation or condition occurs in a patient that is beyond the RNP’s knowledge and experience.

B. In addition to the scope of practice permitted a registered nurse, a registered nurse practitioner, under A.R.S. §§ 32-1601(19) and 32-1606(B)(12), may perform the following acts within the limits of the population focus of certification:

1. Examine a patient and establish a medical diagnosis by client history, physical examination, and other criteria.

2. For a patient who requires the services of a health care facility: admit the patient to the facility, manage the care the patient receives in the facility, and discharge the patient from the facility.

3. Order and interpret laboratory, radiographic, and other diagnostic tests, and perform those tests that the RNP is qualified to perform.

4. Prescribe, order, administer and dispense therapeutic measures including pharmacologic agents and devices if authorized under R4-19-511, and non-pharmacological interventions
including, but not limited to, durable medical equipment, nutrition, home health care, hospice, physical therapy, and occupational therapy.

5. Identify, develop, implement, and evaluate a plan of care for a patient to promote, maintain, and restore health.

6. Perform therapeutic procedures that the RNP is qualified to perform.

7. Delegate therapeutic measures to qualified assistive personnel including assistants under R4-19-509.

8. Perform additional acts that the RNP is qualified to perform and that are generally recognized as being within the role and population focus of certification.

*Citation: ARIZ. ADMIN. CODE § R4-19-508.*

**Arkansas**

“Practice of certified nurse practitioner nursing” means the performance for compensation of advanced nursing practices by a registered nurse who, as demonstrated by national certification, has advanced knowledge and practice skills in the delivery of nursing services.
“Practice of registered nurse practitioner nursing” means the performance for compensation of nursing practices by a registered nurse practitioner that are relevant to the delivery of healthcare services in collaboration with and under the direction of a licensed physician or under the direction of protocols developed with a licensed physician.

A registered nurse practitioner is authorized to engage in nursing practices as recognized by the nursing profession and as authorized by the board.

California

a. Notwithstanding any other provision of law, in addition to any other practices that meet the general criteria set forth in statute or regulation for inclusion in standardized procedures developed through collaboration among administrators and health professionals, including physicians and surgeons and nurses, pursuant to Section 2725, standardized procedures may be implemented that authorize a nurse practitioner to do any of the following:
1. Order durable medical equipment, subject to any limitations set forth in the standardized procedures. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

2. After performance of a physical examination by the nurse practitioner and collaboration with a physician and surgeon, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

3. For individuals receiving home health services or personal care services, after consultation with the treating physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.

*Citation: Cal. Bus. & Prof. Code § 2835.7(a).*

Nothing in this article shall be construed to limit the scope of practice of a registered nurse authorized pursuant to this chapter.

*Citation: Cal. Bus. & Prof. Code § 2837.*
Nothing in this article shall be construed to limit the scope of practice of the registered nurse authorized pursuant to the Business and Professions Code, Division 2, Chapter 6. The nurse practitioner shall function within the scope of practice as specified in the Nurse Practice Act and as it applies to all registered nurses.

Citation: CAL. CODE REG. tit. 16, § 1485.

**Colorado**

a. In order to enhance the cost efficiency and continuity of care, an advanced practice nurse may, within his or her scope of practice and within the advanced practice nurse-patient relationship, sign an affidavit, certification, or similar document that:
   
   I. Documents a patient’s current health status;
   
   II. Authorizes continuing treatment, tests, services, or equipment; or
   
   III. Gives advance directives for end-of-life care.

b. Such affidavit, certification, or similar document may not:
   
   I. Be the prescription of medication unless the advanced practice nurse
has been granted prescriptive authority pursuant to section 12-38-111.6; or
II. Be in conflict with other requirements of law.

_Citation: COLO. REV. STAT. ANN. §12-38-111.5(7)._ 

a. “Practice of advanced practice nursing” means an expanded scope of professional nursing in a scope, role, and population focus approved by the board, with or without compensation or personal profit, and includes the practice of professional nursing, as defined in subsection (10) of this section.

b. “Practice of advanced practice nursing” includes prescribing medications as may be authorized pursuant to section 12-38-111.6.

c. Nothing in this subsection (8.5) shall alter the definition of the practice of professional nursing, as defined in subsection (10) of this section.

_Citation: COLO. REV. STAT. ANN. § 12-38-103(8.5)._ 

“Practice of professional nursing” means the performance of both independent nursing functions and delegated medical functions in accordance with accepted practice standards. Such functions include
the initiation and performance of nursing care through health promotion, supportive or restorative care, disease prevention, diagnosis and treatment of human disease, ailment, pain, injury, deformity, and physical or mental condition using specialized knowledge, judgment, and skill involving the application of biological, physical, social, and behavioral science principles required for licensure as a professional nurse pursuant to section 12-38-111.

The “practice of professional nursing” shall include the performance of such services as:

I. Evaluating health status through the collection and assessment of health data;
II. Health teaching and health counseling;
III. Providing therapy and treatment that is supportive and restorative to life and well-being either directly to the patient or indirectly through consultation with, delegation to, supervision of, or teaching of others;
IV. Executing delegated medical functions;
V. Referring to medical or community agencies those patients who need further evaluation or treatment;
VI. Reviewing and monitoring therapy and treatment plans.
A nurse who meets the definition of advanced practice nurse . . . may be granted prescriptive authority as a function in addition to those defined in Section 12-38-103(10).

The scope of practice for an advanced practice nurse may be determined by the board in accordance with this article.

Connecticut
Advanced nursing practice is defined as the performance of advanced level nursing practice activities that, by virtue of post-basic specialized education and experience, are appropriate to and may be performed by an advanced practice registered nurse. The advanced practice registered nurse performs acts of diagnosis and treatment of alteration in health status as described in subsection (a) of this section and may collaborate with a physician licensed to practice medicine in this state. In all settings, the advanced practice registered
nurse may, in collaboration with a physician licensed to practice medicine in this state, prescribe, dispense, and administer medical therapeutics and corrective measures and may request, sign for, receive, and dispense drugs in the form of professional samples.

An advanced practice registered nurse licensed under the provisions of this chapter may make the determination and pronouncement of death of a patient.


**Delaware**

“Independent practice” means practice and prescribing by an advanced practice registered nurse who is not subject to a collaborative agreement and works outside the employment of an established health-care organization, health-care delivery system, physician, podiatrist, or practice group owned by a physician or podiatrist. Independent practice shall be in an area substantially related to the population and focus of the APRN’s education, and certification.

_Citation:_ Del. Code Ann. tit. 24, § 1902(k).
The Board of Nursing grants full-practice and prescriptive authority upon the issuance of an APRN license. The granting of full-practice authority does not equate to the granting of independent practice.

An APRN licensed by the Board of Nursing with full-practice authority is authorized within the APRN’s role and population foci to:

1. Prescribe, procure, administer, store, dispense, and furnish over the counter, legend and controlled substances pursuant to applicable state and federal laws and within the APRN’s role and population foci.
2. Plan and initiate a therapeutic regimen within the APRN’s role and population foci that includes ordering and prescribing nonpharmacological interventions, including:
   (a) Medical devices and durable medical equipment, nutrition, blood, and blood products.
   (b) Diagnostic and supportive services including home health care, hospice, and physical and occupational therapy.
3. Diagnose, prescribe and institute therapy or referrals of patients within the APRN’s role and population foci to health-care agencies,
health-care providers and community resources.

4. Sign death certificates in all circumstances, subject to the restrictions set forth in the definition of the term “practice of professional nursing” as provided in this chapter.
   
   (c) APRNs with full-practice authority shall seek consultation regarding treatment and care of patients as appropriate to patient needs and the APRN’s level of expertise and scope of practice.
   
   (d) An APRN may be designated as the primary care provider by an insurer or health-care services corporation.
   
   (e) An APRN granted independent practice shall not be held to any lesser standard of care than that of a physician providing care to a specific patient condition or population.
   
   (f) Any APRN rendering services in person or by electronic means in Delaware must hold an active Delaware RN and APRN license.
   
   (g) APRNs shall obtain approval from the APRN Committee and Board of
Nursing pursuant to this chapter in order to practice independently.

*Citation:* [Del. Code Ann. tit. 24, § 1935](#).

Generic functions of the Advanced Practice Nurse within the Specialized Scope of Practice include, but are not limited to:

- Eliciting detailed health history(s)
- Defining nursing problem(s)
- Performing physical examination(s)
- Collecting and performing laboratory tests
- Interpreting laboratory data
- Initiating requests for essential laboratory procedures
- Initiating requests for essential x-rays
- Screening patients to identify abnormal problems
- Initiating referrals to appropriate resources and services as necessary
- Initiating or modifying treatment and medications within established guidelines
- Assessing and reporting changes in the health of individuals, families, and communities
- Providing health education through teaching and counseling
- Planning and/or instituting health care programs in the community with other health care
professionals and the public

- Delegating tasks appropriately
- Prescribing medications and treatments independently pursuant to Rules and Regulations . . .
- Removing epidural catheters

_Citation:_ DEL. NURSING REGS. tit. 24, ch. 1900, § 8.7.

**District of Columbia**

The advanced practice registered nurse may perform actions of medical diagnosis, treatment, prescription, and other functions authorized by this subchapter.

_Citation:_ D.C. STAT. § 3-1206.01(a).

An advanced practice registered nurse may:

1. Initiate, monitor, and alter drug therapies;
2. Initiate appropriate therapies or treatments;
3. Make referrals for appropriate therapies or treatments; and
4. Perform additional functions within his or her specialty determined in accordance with rules and regulations promulgated by the board.

_Citation:_ D.C. STAT. § 3-1206.04.
“Practice of advanced practice registered nursing” means the performance of advanced-level nursing actions, with or without compensation, by a licensed registered nurse with advanced education, knowledge, skills, and scope of practice who has been certified to perform such actions by a national certifying body acceptable to the Board of Nursing. The practice of advanced practice registered nursing includes:

A. Advanced assessment;
B. Medical diagnosis;
C. Prescribing;
D. Selecting, administering, and dispensing therapeutic measures;
E. Treating alterations of the health status; and
F. Carrying out other functions identified in subchapter VI of this chapter and in accordance with procedures required by this chapter.

Citation: D.C. STAT. § 3-1201.02(2).

Florida
An advanced registered nurse practitioner shall perform those functions authorized in this section within the framework of an established protocol that is filed with the board upon biennial license renewal
and within 30 days after entering into a supervisory relationship with a physician or changes to the protocol. The board shall review the protocol to ensure compliance with applicable regulatory standards for protocols. The board shall refer to the department licensees submitting protocols that are not compliant with the regulatory standards for protocols. A practitioner currently licensed under chapter 458, chapter 459, or chapter 466 shall maintain supervision for directing the specific course of medical treatment. Within the established framework, an advanced registered nurse practitioner may:

a. Prescribe, dispense, administer, or order any drug; however, an advanced registered nurse practitioner may prescribe and dispense a controlled substance as defined in s. 893.03 only if the ARNP has graduated from a program leading to a master’s or doctoral degree in a clinical nursing specialty area with training in specialized practitioner skills.

b. Initiate appropriate therapies for certain conditions.

c. Perform additional functions as may be determined by rule . . .

d. Order diagnostic tests and physical and occupational therapy.
In addition to the general functions specified in subsection (3), an advanced registered nurse practitioner may perform the following acts within his or her specialty:

(c) The nurse practitioner may perform any and all of the following acts within the framework of established protocol:

1. Manage selected medical problems.
2. Order physical and occupational therapy.
3. Initiate, monitor, or alter therapies for certain uncomplicated acute illnesses.
4. Monitor and manage patients with stable chronic diseases.
5. Establish behavioral problems and diagnosis and make treatment recommendations.

Within the context of advanced or specialized nursing practice, the advanced registered nurse practitioner may perform acts of nursing diagnosis
and nursing treatment of alterations of the health status. The advanced registered nurse practitioner may also perform acts of medical diagnosis and treatment, prescription, and operation as authorized within the framework of an established supervisory protocol.

_Citation:_ FLA. STAT. ch. 464.003(2).

**Georgia**
The nurse practitioner provides advanced practice nursing care and medical services specific to the nurse practitioner’s respective specialty to individuals, families, and groups, emphasizing health promotion and disease prevention as well as the diagnosis and management of acute and chronic diseases. The nurse practitioner collaborates as necessary with a variety of individuals to diagnose and manage clients’ healthcare problems.

_Citation:_ GA. COMP. R. & REGS. r. 410-11-.03(2)(a).

The advanced practice registered nurse is authorized to perform advanced nursing functions and certain medical acts which include, but are not limited to, ordering drugs, treatments, and
diagnostic studies as provided in O.C.G.A. 43-24-26.1 and Chapter 410.11.

_Citation:_ GA. COMP. R. & REGS. r. 410-11-.01(4b).

**Hawaii**

In addition to those functions specified for the registered nurse, and in accordance with appropriate nationally recognized standards of practice, the advanced practice registered nurse may perform the following generic acts which include, but are not limited to:

1. Provide direct nursing care by utilizing advanced practice scientific knowledge, skills, nursing and related theories to assess, plan, and implement appropriate health and nursing care to patients;

2. Provide indirect care. Plan, guide, evaluate, and direct the nursing care given by other personnel associated with the health care team;

3. Teach, counsel, or plan care for individuals or group, utilizing a synthesis of advanced skills, theories, and knowledge of biologic, pharmacologic, physical, sociocultural and psychological aspects of care to accomplish desired objectives;
4. Serve as a consultant and resource of advanced clinical knowledge and skills to those involved directly or indirectly in patient care;

5. Participate in joint and periodic evaluation of services rendered including, but not limited to, chart reviews, case reviews, patient evaluations, and outcome of case statistics;

6. Establish collaborative, consultative, and referral networks as appropriate with other health care professionals. Patients who require care beyond the scope of practice of an APRN shall be referred to an appropriate health care provider;

7. Manage the plan of care prescribed for the patient;

8. Initiate and maintain accurate records and authorize appropriate regulatory and other legal documents;

9. Recognize, develop, and implement professional and community educational programs related to health care;

10. Conduct research and analyze the health needs of individuals and populations and design programs which target at-risk groups and cultural and environmental factors which foster health and prevent illness;
11. Participate in policy analysis and development of new policy initiative in the area of practice specialty; and

12. Contribute to the development, maintenance, and change of health care delivery systems to improve quality of health care services and consumer access to services.

Citation: HAW. ADMIN. R. §16-89-81(b).

Nurse practitioner scope of practice, depending on area of specialty, may include, but is not limited to:

A. Evaluate the physical and psychosocial health status of patients through a comprehensive health history and physical examination, or mental status examination, using skills of observation, inspection, palpation, percussion, and auscultation, and using diagnostic instruments or procedures that are basic to the clinical evaluation of physical, developmental, and psychological signs and symptoms;

B. Order, interpret, or perform diagnostic, screening, and therapeutic examinations, tests and procedures.

C. Formulate a diagnosis;

D. Plan, implement, and evaluate care;
E. Order or utilize medical, therapeutic, or corrective measures, including, but not limited to, rehabilitation therapies, medical nutritional therapy, social services and psychological and other medical services;

F. Monitor the effectiveness of therapeutic interventions;

G. Assist in surgery; and

H. Admit and discharge clients for inpatient care at facilities licensed as hospitals, long term care facilities or hospice.

Citation: HAW. ADMIN. R. § 16-89-81(c)(1).

Practice as an advanced practice registered nurse means the scope of nursing in a category approved by the board, regardless of compensation or personal profit, and includes the registered nurse scope of practice. The scope of an advanced practice registered nurse includes but is not limited to advanced assessment; telehealth; and the diagnosis, prescription, selection, and administration of therapeutic measures including over the counter drugs, legend drugs, and controlled substances within the advanced practice registered nurse’s role and specialty-appropriate education and certification.
In preparing a certificate of death or fetal death the person in charge of the disposition of the body shall:

(2) Present the certificate of death to the physician or advanced practice registered nurse last in attendance upon the deceased, . . . , who shall thereupon certify the cause of death to the physician’s or advanced practice registered nurse’s best knowledge and belief, or present the certificate of fetal death to the physician, advanced practice registered nurse, midwife, or other person in attendance at the fetal death, who shall certify the fetal death and such medical data pertaining thereto as can be furnished; . . .

“Health care provider” means a person qualified by the director to render health care and service and who has a license for the practice of:
1. Medicine or osteopathy under chapter 453; . . .


_Citation_: HAW. REV. STAT. § 386-1.

(a) Notwithstanding any law to the contrary, the medical use of marijuana by a qualifying patient shall be permitted only if:

1. The qualifying patient has been diagnosed by a physician or advanced practice registered nurse as having a debilitating medical condition;

2. The qualifying patient’s physician or advanced practice registered nurse has certified in writing that, in the physician’s or advanced practice registered nurse’s professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the health risks for the particular qualifying patient; . . .

_Citation_: HAW. REV. STAT. § 329-122.

_Idaho_
An advanced practice registered nurse is authorized to perform advanced nursing practice, which may include the prescribing, administering and dispensing of therapeutic pharmacologic agents, as defined by board rules. An advanced practice registered nurse shall perform only those acts as provided by the board and for which the individual is educationally prepared.

*Citation: IDAHO CODE § 54-1402(1).*

Advanced Practice Registered Nurse. Means a registered nurse licensed in this state who has gained additional specialized knowledge, skills and experience through a graduate or post-graduate program of study as defined herein and is authorized to perform advanced nursing practice, which may include acts of diagnosis and treatment, and the prescribing, administering and dispensing of therapeutic pharmacologic and non-pharmacologic agents, as defined herein.

*Citation: IDAHO ADMIN. CODE §23.01.01: 271.02.*

The advanced practice registered nurse is a licensed independent practitioner who shall practice consistent with the definition of advanced practice
registered nursing, recognized national standards and the standards set forth in these rules.

a. The advanced practice registered nurse shall provide client services for which the advanced practice registered nurse is educationally prepared and for which competence has been achieved and maintained.

b. The advanced practice registered nurse shall recognize his limits of knowledge and experience and shall consult and collaborate with and refer to other health care professionals as appropriate.

c. The advanced practice registered nurse shall evaluate and apply current evidence-based research findings relevant to the advanced nursing practice role.

d. The advanced practice registered nurse shall assume responsibility and accountability for health promotion and maintenance as well as the assessment, diagnosis and management of client conditions to include the use of pharmacologic and non-pharmacologic interventions and the prescribing and dispensing of pharmacologic and non-pharmacologic agents.
e. The advanced practice registered nurse shall use advanced practice knowledge and skills in teaching and guiding clients and other health care team members.

f. The advanced practice registered nurse shall have knowledge of the statutes and rules governing advanced nursing practice, and shall practice within the established standards for the advanced nursing practice role and population focus.

g. The advanced practice registered nurse shall practice consistent with Subsections 400.01 and 400.02 of these rules.

_Citation_: **IDAHO ADMIN. CODE** §23.01.01: 280.02.

In addition to core standards, the advanced practice registered nurse in the role of certified nurse practitioner provides initial and ongoing comprehensive primary care services to clients including, but not limited to, diagnosis and management of acute and chronic disease, and health promotion, disease prevention, health education counseling, and identification and management of the effects of illness on clients and their families.

_Citation_: **IDAHO ADMIN. CODE** §23.01.01: 280.05.
Illinois

a. Advanced practice nursing by certified nurse practitioners, certified nurse anesthetists, certified nurse midwives, or clinical nurse specialists is based on knowledge and skills acquired throughout an advanced practice nurse’s nursing education, training, and experience.

b. Practice as an advanced practice nurse means a scope of nursing practice, with or without compensation, and includes the registered nurse scope of practice.

c. The scope of practice of an advanced practice nurse includes, but is not limited to, each of the following:
   1. Advanced nursing patient assessment and diagnosis.
   2. Ordering diagnostic and therapeutic tests and procedures, performing those tests and procedures when using health care equipment, and interpreting and using the results of diagnostic and therapeutic tests and procedures ordered by the advanced practice nurse or another health care professional.
   3. Ordering treatments, ordering or applying appropriate medical devices,
and using nursing medical, therapeutic, and corrective measures to treat illness and improve health status.

4. Providing palliative and end-of-life care.

5. Providing advanced counseling, patient education, health education, and patient advocacy.

6. Prescriptive authority as defined in Section 65-40 of this Act.

7. Delegating selected nursing activities or tasks to a licensed practical nurse, a registered nurse, or other personnel.

Citation: 225 ILL. COMP. STAT. § 65/65-30. [Section scheduled for repeal on January 1, 2018.]

Indiana

[Indiana law does not use the words “scope of practice,” but describes “standards for each nurse practitioner” as follows:]

1. Assess clients by using advanced knowledge and skills to:
   A. identify abnormal conditions;
   B. diagnose health problems;
   C. develop and implement nursing treatment plans;
   D. evaluate patient outcomes; and
E. collaborate with or refer to a practitioner, as defined in IC 25-23-1-19.4, in managing the plan of care.

2. Use advanced knowledge and skills in teaching and guiding clients and other health team members.

3. Use appropriate critical thinking skills to make independent decisions, commensurate with the autonomy, authority, and responsibility of a nurse practitioner.

4. Function within the legal boundaries of their advanced practice area and shall have and utilize knowledge of the statutes and rules governing their advanced practice area, including the following:
   A. State and federal drug laws and regulations.
   B. State and federal confidentiality laws and regulations.
   C. State and federal medical records access laws.

5. Consult and collaborate with other members of the health team as appropriate to provide reasonable client care, both acute and ongoing.
6. Recognize the limits of individual knowledge and experience, and consult with or refer clients to other health care providers as appropriate.

7. Retain professional accountability for any delegated intervention, and delegate interventions only as authorized by IC 25-23-1 and this title.

8. Maintain current knowledge and skills in the nurse practitioner area.

9. Conduct an assessment of clients and families, which may include health history, family history, physical examination, and evaluation of health risk factors.

10. Assess normal and abnormal findings obtained from the history, physical examination, and laboratory results.

11. Evaluate clients and families regarding development, coping ability, and emotional and social well-being.


13. Develop individualized teaching plans with each client based on health needs.

14. Counsel individuals, families, and groups about health and illness and promote attention to wellness.

15. Participate in periodic or joint evaluations of services rendered, including, but not limited
to, the following:
   A. Chart reviews.
   B. Client evaluations.
   C. Outcome statistics.

16. Conduct and apply research findings appropriate to the area of practice.

17. Participate, when appropriate, in the joint review of the plan of care.

_Citation:_ IND. ADMIN. CODE tit. 848, r. 4-2-1.

The board shall establish a program under which advanced practice nurses who meet the requirements established by the board are authorized to prescribe legend drugs, including controlled substances (as defined in IC 35-48-1-9).

c. The authority granted by the board under this section:
   1. expires on October 31 of the odd-numbered year following the year the authority was granted or renewed; and
   2. is subject to renewal indefinitely for successive periods of two (2) years.

d. The rules adopted under section 7 of this chapter concerning the authority of advanced
practice nurses to prescribe legend drugs must do the following:

1. Require an advanced practice nurse or a prospective advanced practice nurse who seeks the authority to submit an application to the board.

2. Require, as a prerequisite to the initial granting of the authority, the successful completion by the applicant of a graduate level course in pharmacology providing at least two (2) semester hours of academic credit.

3. Require, as a condition of the renewal of the authority, the completion by the advanced practice nurse of the continuing education requirements set out in section 19.7 of this chapter.

*Citation: INDIANA CODE §25-23-1-19.5(a).*

**Iowa**

In the advanced role, the nurse practices nursing assessment, intervention, and management within the boundaries of the nurse-client relationship. Advanced nursing practice occurs in a variety of settings within an interdisciplinary healthcare team, which provides for consultation, collaborative management, and referral. The ARNP may perform
selected medically designated functions when a collaborative practice agreement exists.

*Citation:* IOWA ADMIN. CODE r. 655-6.1(152).

**Kansas**

Each “advanced practice registered nurse” (APRN), as defined by K.S.A. 65-1113 and amendments thereto, shall function in an expanded role to provide primary, secondary, and tertiary health care in the APRN’s role of advanced practice. Each APRN shall be authorized to make independent decisions about advanced practice nursing needs of families, patients, and clients and medical decisions based on the authorization for collaborative practice with one or more physicians. This regulation shall not be deemed to require the immediate and physical presence of the physician when care is given by an APRN. Each APRN shall be directly accountable and responsible to the consumer.

*Citation:* KAN. ADMIN. REGS. § 60-11-101(a).

Each advanced registered nurse practitioner in the category of nurse practitioner shall function in an expanded role at a specialized level, through the application of advanced knowledge and skills and shall be authorized to perform the following:
a. Provide health promotion and maintenance, disease prevention, and independent nursing diagnosis, as defined in K.S.A. 65-1113(b) and amendments thereto, and treatment, as defined in K.S.A. 65-1113(c) and amendments thereto, of acute and chronic diseases;

b. develop and manage the medical plan of care for patients or clients, based on the authorization for collaborative practice;

c. provide health care services for which the nurse practitioner is educationally prepared and for which competency has been established and maintained. Educational preparation may include academic coursework, workshops, institutes, and seminars if theory or clinical experience, or both, are included;

d. provide health care for individuals by managing health problems encountered by patients and clients; and

e. provide innovation in evidence-based nursing practice based upon advanced clinical expertise, decision making, and leadership skills and serve as a consultant, researcher, and patient advocate for individuals, families, groups, and communities to achieve quality, cost-effective patient outcomes and solutions.
An advanced practice registered nurse may prescribe drugs pursuant to a written protocol as authorized by a responsible physician.

Kentucky

“Advanced practice registered nursing” means the performance of additional acts by registered nurses who have gained advanced clinical knowledge and skills through an accredited education program that prepares the registered nurse for one (1) of the four (4) APRN roles; who are certified by the American Nurses’ Association or other nationally established organizations or agencies recognized by the board to certify registered nurses for advanced practice registered nursing as a certified nurse practitioner, certified registered nurse anesthetist, certified nurse midwife, or clinical nurse specialist; and who are certified in at least one (1) population focus. The additional acts shall, subject to approval of the board, include but not be limited to, prescribing treatment, drugs, devices, and ordering diagnostic tests. Advanced practice registered nurses who engage in these additional acts shall be authorized to issue prescriptions for and dispense
nonscheduled legend drugs as defined in KRS 217.905 and to issue prescriptions for but not to dispense Schedules II through V controlled substances as classified in KRS 218A.060, 218A.070, 218A.080, 218A.090, 218A.100, 218A.110, 218A.120, and 218A.130, under the conditions set forth in KRS 314.042 and regulations promulgated by the Kentucky Board of Nursing on or before August 15, 2006.

a.

1. Prescriptions issued by advanced practice registered nurses for Schedule II controlled substances classified under KRS 218A.060, except hydrocodone combination products as defined in KRS 218A.010, shall be limited to a seventy-two (72)-hour supply without any refill.

2. Prescriptions issued by advanced practice registered nurses for hydrocodone combination products as defined in KRS 218A.010 shall be limited to a thirty (30)-day supply without any refill.

3. Prescriptions issued under this subsection for psychostimulants may be written for a thirty (30)-day supply
only by an advanced practice registered nurse certified in psychiatric-mental health nursing who is providing services in a health facility as defined in KRS Chapter 216B or in a regional services program for mental health or individuals with an intellectual disability as defined in KRS Chapter 210.

b. Prescriptions issued by advanced practice registered nurses for Schedule III controlled substances classified under KRS 218A.080 shall be limited to a thirty (30)-day supply without any refill. Prescriptions issued by advanced practice registered nurses for Schedules IV and V controlled substances classified under KRS 218A.100 and 218A.120 shall be limited to the original prescription and refills not to exceed a six (6)-month supply.

Citation: KY. REV. STAT. ANN. § 314.011(8).

(1) The practice of the advanced practice registered nurse shall be in accordance with the standards and functions defined in the scope and standards of practice statements
adopted by the board in subsection (2) of this section.

(2) The following scope and standards of practice statements shall be adopted:

(a) AACN Scope and Standards for Acute Care Nurse Practitioner Practice;

(b) AACN Scope and Standards for Acute Care Clinical Nurse Specialist Practice;

(c) Neonatal Nursing: Scope and Standards of Practice;

(d) Nursing: Scope and Standards of Practice;

(e) Pediatric Nursing: Scope and Standards of Practice;

(f) Psychiatric-Mental Health Nursing 2nd Edition: Scope and Standards of Practice;

(g) Scope of Practice for Nurse Practitioners;

(h) Standards of Practice for Nurse Practitioners;

(i) Scope of Nurse Anesthesia Practice;
(j) Standards for Nurse Anesthesia Practice;

(k) Standards for Office Based Anesthesia Practice;

(l) Standards for the Practice of Midwifery;

(m) Statement on the Scope and Standards of Oncology Nursing Practice: Generalist and Advanced Practice; and

(n) The Women’s Health Nurse Practitioner: Guidelines for Practice and Education.

- In the performance of advanced practice registered nursing, the advanced practice registered nurse shall seek consultation or referral in those situations outside the advanced practice registered nurse’s scope of practice.

- Advanced practice registered nursing shall include prescribing medications and ordering treatments, devices, and diagnostic tests which are consistent with the
scope and standard of practice of the advanced practice registered nurse.

- Advanced practice registered nursing shall not preclude the practice by the advanced practice registered nurse of registered nursing practice as defined in KRS 314.011(6).

_Citation:_ 201 Ky. Adm. Regs. § 20:057 Sections 2–5.

**Louisiana**

An advanced practice registered nurse shall practice as set forth in R.S. 37:913(3)(a) and the standards set forth in these administrative rules. The patient services provided by an APRN shall be in accord with the educational preparation of that APRN. . . .

Standards of practice are essential for safe practice by the APRN and shall be in accordance with the published professional standards for each recognized specialty and functional role. The core standards for all categories of advanced practice registered nurses include, but are not limited to:
1. an APRN shall meet the standards of practice for registered nurses as defined in LAC 46:XLVII.3901-3915;
2. an APRN shall assess patients at an advanced level, identify abnormal conditions, analyze and synthesize data to establish a diagnosis, develop and implement treatment plans, and evaluate patient outcomes;
3. the APRN shall use advanced knowledge and skills in providing patients and health team members with guidance and teaching;
4. an APRN shall use critical thinking and independent decision-making at an advanced level commensurate with the autonomy, authority, and responsibility of the specialty and functional role while working with patients and their families in meeting health care needs;
5. an APRN shall demonstrate knowledge of the statutes and rules governing advanced registered nursing practice and function within the legal boundaries of the appropriate advanced registered nursing practice role;
6. an APRN shall demonstrate knowledge of and apply current nursing research findings relevant to the advanced nursing specialty and functional role;
7. an APRN shall make decisions to solve patient care problems and select medical treatment regimens in collaboration with a licensed physician or dentist; and
8. an APRN shall retain professional accountability for his/her actions and/or interventions.

Citation: LA. ADMIN. CODE tit. 46, § XLVII-4513.

a. “Advanced practice registered nursing” means nursing by a certified registered nurse anesthetist, certified nurse midwife, clinical nurse specialist, or nurse practitioner which is based on knowledge and skills acquired in a basic nursing education program, licensure as a registered nurse, and a minimum of a master’s degree with a concentration in the respective advanced practice nursing specialty which includes both didactic and clinical components, advanced knowledge in nursing theory, physical and psychosocial assessment, nursing interventions, and management of health care. Advanced practice registered nursing includes:

   i. Assessing patients, analyzing and synthesizing data, and knowledge of
and applying nursing principles at an advanced level.

ii. Providing guidance and teaching.

iii. Working with patients and families in meeting health care needs.

iv. Collaborating with other health care providers.

v. Managing patients’ physical and psychosocial health-illness status with regard to nursing care.

vi. Utilizing research skills.

vii. Analyzing multiple sources of data and performing certain acts of medical diagnosis in accordance with the collaborative practice agreement.

viii. Making decisions in solving patient care problems and selecting treatment regimens in collaboration with a licensed physician, dentist, or other health care provider as indicated.

ix. Consulting with or referring patients to licensed physicians, dentists, and other health care providers in accordance with a collaborative practice agreement.

b. Advanced practice registered nursing may include certain acts of medical diagnosis, in
accordance with R.S. 37:913(8) and (9), or medical prescriptions of therapeutic or corrective nature, prescribing assessment studies, legend and certain controlled drugs, therapeutic regimens, medical devices and appliances, receiving and distributing a therapeutic regimen of prepackaged drugs prepared and labeled by a licensed pharmacist, and free samples supplied by a drug manufacturer, and distributing drugs for administration to and use by other individuals within the scope of practice as defined by the board and in accordance with this Paragraph.

_Citation:_ LA. REV. STAT. § 37:913(3).

**Maine**
The certified nurse practitioner shall provide only those health care services for which the certified nurse practitioner is educationally and clinically prepared, and for which competency has been maintained. The Board reserves the right to make exceptions. Such health care services, for which the certified nurse practitioner is independently responsible and accountable, include:

1. obtaining a complete health data base that includes a health history, physical
examination, and screening and diagnostic evaluation
2. interpreting health data by identifying wellness and risk factors and variations from norms
3. diagnosing and treating common diseases and human responses to actual and potential health problems
4. counseling individuals and families
5. consulting and/or collaborating with other healthcare providers and community resources
6. referring client to other health care providers and community resources.

Citation: COde ME. R. § 02 380 ChAPTer 8 Section 1(3)(A).

“Advanced practice registered nursing” means the delivery of expanded professional health care by an advanced practice registered nurse that is:

Within the advanced practice registered nurse’s scope of practice as specified by the board of rulemaking, taking into consideration any national standards that exist; and . . . [i]n accordance with the standards of practice for advanced practice registered nurses as specified by the board by
rulemaking, taking into consideration any national standards that may exist. Advanced practice registered nursing includes consultation with or referral to medical and other health care providers when required by client health care needs.

A certified nurse practitioner or a certified nurse midwife who qualifies as an advanced practice registered nurse may prescribe and dispense drugs or devices, or both, in accordance with rules adopted by the board.

A certified nurse practitioner who qualifies as an advanced practice registered nurse must practice, for at least 24 months, under the supervision of a licensed physician or a supervising nurse practitioner or must be employed by a clinic or hospital that has a medical director who is a licensed physician. The certified nurse practitioner shall submit written evidence to the board upon completion of the required clinical experience.

Citation: Me. Rev. Stat. Ann. tit. 32, § 2102-2A.

Maryland
A. A nurse practitioner may independently perform the following functions:
1. A comprehensive physical assessment of patients;

2. In accordance with Family Law Article, §2-301, Annotated Code of Maryland, certify to the clerk of the court that a:
   a. 16 or 17 year old individual, who wants to get married without parental consent, has been examined and found to be pregnant or has given birth to a child; or
   b. 15 year old individual, who has parental consent to be married, has been examined and found to be pregnant or has given birth to a child;

3. In accordance with Transportation Article, §13-704, Annotated Code of Maryland, certify to the Department of Transportation that an individual needs special consideration for certain health reasons;

4. In accordance with Health General Article, §4-208, Annotated Code of Maryland, complete the date of birth and medical information required on a birth certificate;
5. In accordance with Health General Article, §4-212, Annotated Code of Maryland, complete a death certificate if:
   a. The medical examiner does not take charge of the body; and
   b. The deceased was under the care of the nurse practitioner;

6. In accordance with Health General Article, §13-704, Annotated Code of Maryland, conduct education and training to certify individuals for the Insect Sting Emergency Treatment Program;

7. Establish medical diagnosis for common short-term and chronic stable health problems;

8. In accordance with Health General Article, §4-212, Annotated Code of Maryland, file a replacement death certificate;

9. In accordance with Health General Article, §5-601, Annotated Code of Maryland, issue a “do not resuscitate order” on a Maryland Emergency Medical Services form.
10. Order, perform, and interpret laboratory and diagnostic tests;
11. Order and perform diagnostic, therapeutic, and corrective measures;
12. Prescribe drugs;
13. Provide emergency care;
14. Refer patients to appropriate licensed physicians or other health care providers as needed;
15. In accordance with COMAR 20.31.03.01, certify that the utility client has a serious illness or the need for life-support equipment; and

B. A psychiatric nurse practitioner together with a physician is authorized to sign applications:
   1. In accordance with Health General Article, §10-615, Annotated Code of Maryland, to admit a minor to a facility for treatment of a mental disorder; and
   2. In accordance with Health General Article, §10-616, Annotated Code of Maryland, to admit an individual on an
involuntary basis to a facility for treatment of a mental disorder.

C. A nurse practitioner may practice only in the area of specialization in which certified.

D. Nothing in this chapter limits or prohibits a registered nurse from performing those functions which constitute the practice of registered nursing as defined by law.

*Citation: Md. Regs. Code 10 § 27.07.02.*

**Massachusetts**

The practice of registered nurses shall include, but not be limited to:

1. the application of nursing theory to the development, implementation, evaluation, and modification of plans of nursing care for individuals, families and communities;

2. coordination and management of resources for care delivery;

3. management, direction and supervision of the practice of nursing, including the delegation of selected activities to unlicensed assistive personnel.
Advanced practice nurse regulations which govern the ordering of tests, therapeutics, and prescribing of medications shall be promulgated by the board in conjunction with the board of registration in medicine.

*Citation: MASS. GEN. LAWS ch. 112, § 80B.*

Each APRN is responsible and accountable for his or her nursing judgments, actions, and competency.

a. A CNP will only practice in the clinical category(s) for which the CNP has attained and maintained certification. A CNP may attain additional competencies within his or her category(s) consistent with the scope and standards of CNP practice.

b. The scope of CNP practice is reflective of standards for the provision of health care services to individuals throughout the lifespan, including health promotion, disease prevention, health education, counseling and making referrals to other members of the health care team, as well as the diagnosis and management of acute and chronic illness and disease. A CNP provides care in diverse settings, including, but not limited to, home, hospital, nursing facilities, and a variety of
ambulatory care settings including private offices, community and public health clinics.
c. Pursuant to M.G.L.c. 112 § 80I, when a law or rule requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, when relating to physical or mental health, that requirement may be fulfilled by a CNP, provided that the signature, certification, stamp, verification, affidavit, or endorsement is consistent with established scope of practice standards and does not expand the scope of practice of the CNP.
d. Pursuant to St. 2012, c. 369 and M.G.L. c. 112 § 80I, CNPs are authorized to issue written certifications of marijuana for medical use as provided pursuant to the mutually agreed upon guidelines between the NP and the physician supervising the CNP’s prescriptive practice.

_Citation_: CODE MASS. REGS. tit. 244, § 4.06(3).

**Michigan**
Subject to subsections (2) to (6), a licensee who holds a license other than a health profession subfield license may delegate to a licensed or unlicensed individual who is otherwise qualified by education, training or experience the performance of
selected acts, tasks or functions where the acts, tasks, or functions fall within the scope of practice of the licensee’s profession and will be performed under the licensee’s supervision. A licensee shall not delegate an act, task, or function under this section if the act, task, or function, under standards of acceptable and prevailing practice, requires the level of education, skill, and judgment required of the licensee under this article.

_Citation:_ MICH. COMP. LAWS § 333.16215(1).

_Note:_ House Bill 5400, signed in January 2017, added prescribing of nonscheduled drugs to nurse practitioner scope of practice.

**Minnesota**

“Nurse practitioner practice” means the provision of care including:

1. health promotion, disease prevention, health education, and counseling;
2. providing health assessment and screening activities;
3. diagnosing, treating, and facilitating patients’ management of their acute and chronic illnesses and diseases;
4. ordering, performing, supervising, and interpreting diagnostic studies, excluding interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography;
5. prescribing pharmacologic and nonpharmacologic therapies; and
6. consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient.

_Citation_: _Minn. Stat. Ann._ § 148.171(11).

a. The “practice of advanced practice registered nursing” means the performance of an expanded scope of nursing in at least one of the recognized advanced practice registered nurse roles for at least one population focus. The scope and practice standards of an advanced practice registered nurse are defined by the national professional nursing organizations specific to the practice as a clinical nurse specialist, nurse-midwife, nurse practitioner, or registered nurse anesthetist in the population focus. The scope of advanced practice registered nursing includes, but is not limited to, performing acts of advanced
assessment, diagnosing, prescribing, and ordering. The practice includes functioning as a primary care provider, direct care provider, case manager, consultant, educator, and researcher.

b. The practice of advanced practice registered nursing requires the advanced practice registered nurse to be accountable: (1) to patients for the quality of advanced nursing care rendered; (2) for recognizing limits of knowledge and experience; and (3) for planning for the management of situations beyond the advanced practice registered nurse’s expertise. The practice of advanced practice registered nursing includes accepting referrals from, consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient.

Citation: MINN. STAT. ANN. § 148.171(13).

Mississippi
“Advanced nursing practice” means, in addition to the practice of professional nursing, the performance of advanced-level nursing approved by the board which, by virtue of graduate education and experience are appropriately performed by an
advanced practice registered nurse. The advanced practice registered nurse may diagnose, treat, and manage medical conditions. This may include prescriptive authority as identified by the board. Advanced practice registered nurses must practice in a collaborative/consultative relationship with a physician or dentist with an unrestricted license to practice in the State of Mississippi and advanced nursing must be performed within the framework of a standing protocol or practice guidelines, as appropriate.

*Citation:* MISS. NURSING PRACTICE LAW §73-15-5(4).

**Missouri**

RNs recognized by the MSBN as being eligible to practice as an APRN shall function clinically within the professional scope and standards of their advanced practice nursing clinical specialty area and consistent with their formal advanced nursing education and national certification, if applicable, or within their education, training, knowledge, judgment, skill, and competence as an RN.

*Citation:* MO. CODE REGS. ANN. tit. 20, § 2200-4.100(4)(A)(2).
The methods of treatment and the authority to administer, dispense, or prescribe drugs delegated in a collaborative practice arrangement between a collaborating physician and collaborating APRN shall be within the scope of practice of each professional and shall be consistent with each professional's skill, training, education, competence, licensure, and/or certification and shall not be further delegated to any person except that the individuals identified in sections 338.095 and 338.198, RSMo, may communicate prescription drug orders to a pharmacist.

_Citation: Mo. Code Regs. Ann. tit. 20, § 2200-4.200(3)(A)._ 

When a collaborative practice arrangement is utilized to provide health care services for conditions other than acute self-limited or well-defined problems, the collaborating physician, or other physician designated in the collaborative practice arrangement, shall examine and evaluate the patient and approve or formulate the plan of treatment for new or significantly changed conditions as soon as is practical, but in no case more than two (2) weeks after the patient has been seen by the collaborating APRN or RN.
Montana
Certified nurse practitioner (CNP) practice means the independent and/or collaborative management of primary and/or acute health care of individuals, families, and communities across settings. The CNP is certified in acute or primary care and in the population focus of adult/geriatric, pediatric, neonatal, family/individual health across the lifespan, women’s/gender-related, and/or psychiatric/mental health.

The APRN licensed in Montana may only practice in the role and population focus in which the APRN has current national certification. APRN practice is an independent and/or collaborative practice and may include:

a. establishing medical and nursing diagnoses, treating, and managing patients with acute and chronic illnesses and diseases; and
b. providing initial, ongoing, and comprehensive care, including:
i. physical examinations, health assessments, and/or other screening activities;

ii. prescribing legend and controlled substances when prescriptive authority is successfully applied for and obtained;

iii. ordering durable medical equipment, diagnostic treatments and therapeutic modalities, laboratory imaging and diagnostic tests, and supportive services, including, but not limited to, home healthcare, hospice, and physical and occupational therapy;

iv. receiving and interpreting results of laboratory, imaging, and/or diagnostic studies;

v. working with clients to promote their understanding of and compliance with therapeutic regimens;

vi. providing instruction and counseling to individuals, families, and groups in the areas of health promotion, disease prevention, and maintenance, including involving such persons in planning for their health care; and

vii. working in collaboration with other health care providers and agencies to
provide and, where appropriate, coordinate services to individuals and families.

Citation: MONT. ADMIN. R. § 24.159.1406(1).

Nebraska
1. A nurse practitioner may provide health care services within specialty areas. A nurse practitioner shall function by establishing collaborative, consultative, and referral networks as appropriate with other health care professionals. Patients who require care beyond the scope of practice of a nurse practitioner shall be referred to an appropriate health care provider.

2. Nurse practitioner practice means health promotion, health supervision, illness prevention and diagnosis, treatment, and management of common health problems and acute and chronic conditions, including:
   a. Assessing patients, ordering diagnostic tests and therapeutic treatments, synthesizing and analyzing data, and applying advanced nursing principles;
   b. Dispensing, incident to practice only, sample medications which are provided
by the manufacturer and are provided at no charge to the patient; and
c. Prescribing therapeutic measures and medications, relating to health conditions within the scope of practice.

3. A nurse practitioner who has proof of a current certification from an approved certification program in a psychiatric or mental health specialty may manage the care of patients committed under the Nebraska Mental Health Commitment Act. Patients who require care beyond the scope of practice of a nurse practitioner who has proof of a current certification from an approved certification program in a psychiatric or mental health specialty shall be referred to an appropriate health care provider.

4. A nurse practitioner may pronounce death and may complete and sign death certificates and any other forms if such acts are within the scope of practice of the nurse practitioner and are not otherwise prohibited by law.

_Citation:_ NEB. REV. STAT. § 38-2315.

_Nevada_
1. The Board may issue a license to practice as an advanced practice registered nurse to a registered nurse who has completed an educational program designed to prepare a registered nurse to:
   a. Perform designated acts of medical diagnosis;
   b. Prescribe therapeutic or corrective measures; and
   c. Prescribe controlled substances, poisons, dangerous drugs and devices, and who meets any other requirements established by the Board for such licensure.

2. An advanced practice registered nurse may:
   a. Engage in selected medical diagnosis and treatment; and
   b. If authorized pursuant to NRS 639.2351 and subject to the limitations set forth in subsection 3, prescribe controlled substances, poisons, dangerous drugs and devices.

An advanced practice registered nurse shall not engage in any diagnosis, treatment or other conduct which the advanced practice registered nurse is not qualified to perform.
3. An advanced practice registered nurse who is authorized to prescribe controlled substances, poisons, dangerous drugs and devices pursuant to NRS 639.2351 shall not prescribe a controlled substance listed in schedule II unless:
   a. The advanced practice registered nurse has at least 2 years or 2,000 hours of clinical experience; or
   b. The controlled substance is prescribed pursuant to a protocol approved by a collaborating physician.

5. The Board shall adopt regulations:
   a. Delineating the authorized scope of practice of an advanced practice registered nurse.

   Citation: Nev. Rev. Stat. § 632.237.

An advanced practice registered nurse may perform the following acts in addition to the functions of a registered nurse if the advanced practice registered nurse is properly prepared and the acts are currently within the standard of practice for his or her role and population of focus:
1. Systematically assess the health status of persons and families by:
   a. Taking, recording and interpreting medical histories and performing physical examinations; and
   b. Performing or initiating selected diagnostic procedures.

2. Based on information obtained in the assessment of a person’s health, manage the care of selected persons and families with common, acute, recurrent or long-term health problems. Management may include:
   a. Initiation of a program of treatment;
   b. Evaluation of responses to health problems and programs of treatment;
   c. Informing a person or family of the status of the patient’s health and alternatives for care;
   d. Evaluation of compliance with a program of treatment agreed upon by the person or family and the advanced practice registered nurse;
   e. Modification of programs of treatment based on the response of the person or family to treatment;
   f. Referral to appropriate providers of health care; and
g. Commencement of care required to stabilize a patient in an emergency.

3. Any other act if:
   a. The advanced practice registered nurse is certified to perform that act by an organization recognized by the Board;
   b. The performance of the act was taught in the program of education attended by the advanced practice registered nurse;
   c. The performance of the act was taught in a comprehensive program of instruction successfully completed by the advanced practice registered nurse, which included clinical experience;
   d. The act is within the scope of practice of an advanced practice registered nurse as determined by the Board; or
   e. The advanced practice registered nurse is trained to perform that act by a physician or another advanced practice registered nurse and the act:
      1. Has been described as being performed by an advanced practice registered nurse in two
or more national nursing publications, national nursing practice guidelines or national standards for nursing practice, or any combination thereof, which are listed in the Cumulative Index to Nursing and Allied Health Literature, as adopted by reference in NAC 632.110; or

2. Has been individually approved by the Board.

_Citation:_ NEV. ADMIN. CODE § 632.255.

**New Hampshire**

1. Advanced practice registered nursing by nurse practitioners shall consist of a combination of knowledge and skills acquired in basic nursing education. The APRN scope of practice, with or without compensation or personal profit, shall be limited to:

   a. Performing acts of advanced assessment, diagnosing, prescribing, selecting, administering, and providing therapeutic measures and treatment regimes;

   b. Obtaining consultation, planning, and implementing collaborative
management, referral, or transferring
the care of the client as appropriate;
and
c. Providing such functions common to a
nurse practitioner for which the APRN
is educationally and experientially
prepared and which are consistent with
standards established by a national
credentialing or certification body
recognized by the National Council of
State Boards of Nursing and approved
by the board in the appropriate APRN
role and specialty.

II. An APRN shall practice within standards
consistent with standards established by a
national credentialing or certification body
recognized by the National Council of State
Boards of Nursing and approved by the board
in the appropriate APRN role and specialty.
The board shall not approve a new advanced
practice specialty category that has not been
developed by a national credentialing or
certifying body recognized by the National
Council of State Board of Nursing without
approval of the legislature under RSA 332-G:6. Each APRN shall be accountable to
clients and the board:
a. For complying with this chapter and the quality of advanced nursing care rendered;
b. For recognizing limits of knowledge and experience and planning for the management of situations beyond the APRN’s expertise; and
c. For consulting with or referring clients to other healthcare providers as appropriate.

III. An APRN shall have plenary authority to possess, compound, prescribe, administer, and dispense and distribute to clients controlled and noncontrolled drugs within the scope of the APRN’s practice as defined by this chapter. Such authority may be denied, suspended, or revoked by the board after notice and the opportunity for hearing, upon proof that the authority has been abused.

IV. Any expansion of the scope of practice shall be adopted by legislation in accordance with RSA 332-G:6.

Citation: N.H. REv. Stat. ANN. § 326-B:11.

[Effective June 12, 2015, Chapter 144 was amended to grant certain APRNs the ability to
authorize involuntary commitment and voluntary admission to state institutions (Senate Bill 23).

**New Jersey**

a. In addition to all other tasks which a registered professional nurse may, by law, perform, an advanced practice nurse may manage preventive care services, and diagnose and manage deviations from wellness and long-term illnesses, consistent with the needs of the patient and within the scope of practice of the advanced practice nurse, by:

1. initiating laboratory and other diagnostic tests;
2. prescribing or ordering medications and devices, as authorized by subsections b. and c. of this section;
3. prescribing or ordering treatments, including referrals to other licensed health care professionals, and performing specific procedures in accordance with the provisions of this subsection.

f. An attending advanced practice nurse may determine and certify the cause of death of the nurse’s patient and execute the death
certification pursuant to R.S.26:6-8 if no collaborating physician is available to do so and the nurse is the patient’s primary caregiver.

*Citation:* N.J. STAT. ANN. § 45:11-49.a,f.

**New Mexico**

Certified nurse practitioners who have fulfilled requirements for prescriptive authority may prescribe in accordance with the rules, regulations, guidelines, and formularies for individual certified nurse practitioners promulgated by the board.

*Citation:* N.M. STAT. ANN. § 61-3-23.2.C.

Certified nurse practitioners may:

1. Perform an advanced practice that is beyond the scope of practice of professional registered nursing;
2. Practice independently and make decisions regarding health care needs of the individual, family, or community and carry out health regimens, including the prescription and dispensing of dangerous drugs and controlled substances included in Schedule II through V.
of the Controlled Dangerous Substances Act; and

3. Serve as a primary acute, chronic long-term and end-of-life health care provider and as necessary collaborate with licensed medical doctors, osteopathic physicians, or podiatrists.

_Citation:_ N.M. STAT. ANN. § 61-3-23.2.B.

**New York**

The practice of registered professional nursing by a nurse practitioner, certified under section six thousand nine hundred ten of this article, may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures within a specialty area of practice, in collaboration with a licensed physician qualified to collaborate in the specialty involved, provided such services are performed in accordance with a written practice agreement and written practice protocols. . . .

_Citation:_ N.Y. EDUC. LAW, art. 139, § 6902.3(a).

Prescriptions for drugs, devices, and immunizing agents may be issued . . . in accordance with the practice agreement and practice protocols. . . .
North Carolina
A nurse practitioner shall be held accountable by both Boards for the continuous and comprehensive management of a broad range of personal health services for which the nurse practitioner is educationally prepared and for which competency has been maintained, with physician supervision and collaboration as described in Rule .0810 of this Section. These services include but are not restricted to:

1. Promotion and maintenance of health;
2. Prevention of illness and disability;
3. Diagnosis, treating, and managing acute and chronic illnesses;
4. Guidance and counseling for both individuals and families;
5. Prescribing, administering, and dispensing therapeutic measures, tests, procedures and drugs;
6. Planning for situations beyond the nurse practitioner’s expertise, and consulting with and referring to other health care providers as appropriate; and
7. Evaluating health outcomes.
North Dakota

1. Practice as an advanced practice registered nurse may include:
   a. Perform a comprehensive assessment of clients and synthesize and analyze data within a nursing framework;
   b. Identify, develop, plan, and maintain evidence-based, client-centered nursing care;
   c. Prescribe a therapeutic regimen of health care, including diagnosing, prescribing, administering, and dispensing legend drugs and controlled substances;
   d. Evaluate prescribed health care regimen;
   e. Assign and delegate nursing interventions that may be performed by others;
   f. Promote a safe and therapeutic environment;
   g. Provide health teaching and counseling to promote, attain, and maintain the optimum health level of clients;
   h. Communicate and collaborate with the interdisciplinary team in the
management of health care and the implementation of the total health care regimen;
i. Manage and evaluate the clients’ physical and psychosocial health-illness status;
j. Manage, supervise, and evaluate the practice of nursing;
k. Utilize evolving client information management systems;
l. Integrate quality improvement principles in the delivery and evaluation of client care;
m. Teach the theory and practice of nursing;
n. Analyze, synthesize, and apply research outcomes in practice; and
o. Integrate the principles of research in practice.

2. Notwithstanding the above, all services rendered by the licensee shall be commensurate with the academic preparation, knowledge, skills, and abilities of the advanced practice licensed nurse’s experience, continuing education, and demonstrated competencies. The nurse must recognize individual limits of knowledge,
skills, and abilities and plan for situations beyond the licensee’s expertise.

Citation: N.D. ADMIN. CODE § 54-05-03.1-03.2.

Ohio
A nurse authorized to practice as a certified nurse practitioner, in collaboration with one or more physicians or podiatrists, may provide preventive and primary care services, provide services for acute illnesses, and evaluate and promote patient wellness within the nurse’s nursing specialty, consistent with the nurse’s education and certification, and in accordance with rules adopted by the board. A certified nurse practitioner who holds a certificate to prescribe issued under section 4723.48 of the Revised Code may, in collaboration with one or more physicians or podiatrists, prescribe drugs and therapeutic devices in accordance with section 4723.481 of the Revised Code.

When a certified nurse practitioner is collaborating with a podiatrist, the nurse’s scope of practice is limited to the procedures that the podiatrist has the authority under section 4731.51 of the Revised Code to perform.

Citation: OHIO REV. CODE ANN. § 4723-43(C).
Oklahoma

A Certified Nurse Practitioner shall be eligible, in accordance with the scope of practice of the Certified Nurse Practitioner, to obtain recognition as authorized by the Board to prescribe, as defined by the rules promulgated by the Board pursuant to this section and subject to the medical direction of a supervising physician. This authorization shall not include dispensing drugs, but shall not preclude, subject to federal regulations, the receipt of, the signing for, or the dispensing of professional samples to patients.

The Certified Nurse Practitioner accepts responsibility, accountability, and obligation to practice in accordance with usual and customary advanced practice registered nursing standards and functions as defined by the scope of practice/role definition statements for the Certified Nurse Practitioner.

*Citation: OKLA. STAT. ANN. tit. 59, § 567.3a (6).*

The Certified Nurse Practitioner’s (CNP) scope of practice includes the full scope of nursing practice and practice in an expanded role as follows:
1. The Certified Nurse Practitioner (CNP) provides comprehensive health care to clients across the life span.

2. The CNP is responsible and accountable for the continuous and comprehensive management of a broad range of health services, which include, but are not limited to:
   A. promotion and maintenance of health;
   B. prevention of illness and disability;
   C. diagnosis and prescription of medications, treatments, and devices for acute and chronic conditions and diseases;
   D. management of health care during acute and chronic phases of illness;
   E. guidance and counseling services;
   F. consultation and/or collaboration with other healthcare providers and community resources;
   G. referral to other healthcare providers and community resources.

3. The CNP will provide services based upon education, experience, and national certification. It is the responsibility of the licensee to document competency of any act, based upon education, experience and certification.
4. The scope of practice as previously defined is incorporated into the following specialty categories and further delineates the population served:

A. Adult CNP (acute and/or primary) provides acute and/or primary health care to adolescents and adults.
B. Family CNP provides health care to persons across the lifespan.
C. Geriatric CNP provides health care to older adults.
D. Neonatal CNP provides health care to neonates and infants.
E. Pediatric CNP (acute and/or primary) provides acute and/or primary health care to persons from newborn to young adulthood.
F. Women’s Health Care CNP provides health care to adolescent and adult females. Care may also be provided to males with reproductive health needs or problems.
G. Acute Care CNP provides health care to adults who are acutely or critically ill.
H. The Adult Psychiatric and Mental Health CNP provides acute and chronic psychiatric and mental health care to persons age 13 or older.
I. The Family Psychiatric and Mental Health CNP provides acute and chronic psychiatric and mental health care to persons across the lifespan.

J. The Acute Care Pediatric CNP provides health care to persons from newborn to young adulthood with complex acute, critical, and chronic health conditions.

5. Effective January 1, 2016, the applicant for initial APRN licensure or APRN licensure by endorsement as a CNP shall hold certification in at least one of the following population foci: family/individual across the lifespan, adult-gerontology (acute and/or primary), neonatal, pediatrics (acute and/or primary), women’s health/gender related, or psychiatric/mental health.

Citation: OKLA. ADMIN. CODE § 485:10-15-6(b).

Oregon

3. The nurse practitioner provides holistic health care to individuals, families, and groups across the life span in a variety of settings, including hospitals, long-term care facilities, and community-based settings.
4. Within his or her specialty, the nurse practitioner is responsible for managing health problems encountered by the client and is accountable for health outcomes. This process includes:
   a. Assessment;
   b. Diagnosis;
   c. Development of a plan;
   d. Intervention;
   e. Evaluation.

5. The nurse practitioner is independently responsible and accountable for the continuous and comprehensive management of a broad range of health care, which may include:
   a. Promotion and maintenance of health;
   b. Prevention of illness and disability;
   c. Assessment of clients, synthesis and analysis of data and application of nursing principles and therapeutic modalities;
   d. Management of health care during acute and chronic phases of illness;
   e. Admission of his/her clients to hospitals and/or health services including but not limited to home health, hospice, long
term care, and drug and alcohol treatment;
f. Counseling;
g. Consultation and/or collaboration with other care providers and community resources;
h. Referral to other health care providers and community resources;
i. Management and coordination of care;
j. Use of research skills;
k. Diagnosis of health/illness status;
l. Prescribing, dispensing, and administration of therapeutic devices and measures including legend drugs and controlled substances as provided in Division 56 of the Oregon Nurse Practice Act, consistent with the definition of the practitioner’s specialty category and scope of practice.

6. The nurse practitioner scope of practice includes teaching the theory and practice of advanced practice nursing.

7. The nurse practitioner is responsible for recognizing limits of knowledge and experience, and for resolving situations beyond his/her nurse practitioner expertise by
consulting with or referring clients to other health care providers.

8. The nurse practitioner will only provide health care services within the nurse practitioner’s scope of practice for which he/she is educationally prepared and for which competency has been established and maintained. Educational preparation includes academic course work, workshops or seminars, provided both theory and clinical experience are included.

Citation: OR. ADMIN. R. § 851-050-0005.

Pennsylvania
A CRNP . . . while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutics or corrective measures in collaboration with a physician licensed to practice in this Commonwealth. . . .

Citation: 49 P.A. CODE § 21.251.

a. A CRNP may collaborate only with physicians who hold a current license to practice in this Commonwealth.
b. When acting in collaboration with a physician as set forth in a collaborative agreement and within the CRNP’s specialty, a CRNP may:

1. Perform comprehensive assessments of patients and establish medical diagnoses.

2. Order, perform and supervise diagnostic tests for patients and, to the extent the interpretation of diagnostic tests is within the scope of the CRNP’s specialty and consistent with the collaborative agreement, may interpret diagnostic tests.

3. Initiate referrals to and consultations with other licensed professional health care providers, and consult with other licensed professional health care providers at their request.

4. Develop and implement treatment plans, including issuing orders to implement treatment plans. However, only a CRNP with current prescriptive authority approval may develop and implement treatment plans for pharmaceutical treatments.

5. Complete admission and discharge summaries.
6. Order blood and blood components for patients.
7. Order dietary plans for patients.
8. Order home health and hospice care.
10. Issue oral orders to the extent permitted by the health care facilities’ by-laws, rules, regulations or administrative policies and guidelines.
11. Make physical therapy and dietitian referrals.
12. Make respiratory and occupational therapy referrals.
13. Perform disability assessments for the program providing temporary assistance to needy families (TANF).
15. Perform and sign the initial assessment of methadone treatment evaluations, provided that any order for methadone treatment shall be made only by a physician.

Citation: 49 P.A. Code §21.282a.

Rhode Island
“Advanced practice registered nursing” means an independent and expanded scope of nursing in a role and population focus approved by the board of nurse registration and nursing education that includes the registered nurse scope of practice and may include, but is not limited to, performing acts of advanced assessment, diagnosing, prescribing and ordering. Each APRN is accountable to patients, the nursing profession, and the board of nursing for complying with the requirements of this chapter and the quality of advanced nursing care rendered; recognizing limits of knowledge and experience; planning for the management of situations beyond the APRN’s expertise; and for consulting with or referring patients to other health care providers as appropriate.

* Citation: R.I. GEN. LAWS §5-34-3(2). *

“Certified nurse practitioner” is an advanced practice nurse utilizing independent knowledge of physical assessment, diagnosis, and management of health care and illnesses. The practice includes prescriptive privileges. Certified nurse practitioners are members of the health care delivery system practicing in areas including, but not limited to: family practice, pediatrics, adult health care, geriatrics, and women’s health care in primary,
acute, long-term and critical care settings in health care facilities and the community. Certified nurse practitioners may be recognized as the primary care provider or acute-care provider of record.

Citation: R.I. GEN. LAWS §5-34-3(4).

APRNs are licensed, independent practitioners within standards established or recognized by the board of nursing. Each APRN is accountable to patients, the nursing profession, and the board of nursing for:

(1) Complying with the requirements of this chapter and the quality of advanced nursing care rendered;

(2) Recognizing limits of knowledge and experience;

(3) Planning for the management of situations beyond the APRN’s expertise;

(4) Consulting with or referring patients to other licensed health care providers as appropriate.

Citation: R.I. GEN. LAWS §5-34-44.

South Carolina
In addition to those activities considered the practice of registered nursing, an APRN may perform delegated medical acts.

_Citation:_ S.C. _CODE ANN._ § 40-33-20(5).

“Delegated medical acts” means additional acts delegated by a physician or dentist to the NP, CNM, or CNS and may include formulating a medical diagnosis and initiating, continuing, and modifying therapies, including prescribing drug therapy, under approved written protocols. . . . Delegated medical acts must be agreed to jointly by both the Board of Nursing and the Board of Medical Examiners. Delegated medical acts must be performed under the general supervision of a physician or dentist who must be readily available for consultation.

_Citation:_ S.C. _CODE ANN._ § 40-33-20(23).

**South Dakota**

A nurse practitioner may perform the following overlapping scope of advanced practice nursing and medical functions pursuant to § 36-9A-15, including:

1. The initial medical diagnosis and the institution of a plan of therapy or referral;
2. The prescription of medications and provision of drug samples or a limited supply of labeled medications, including controlled drugs or substances listed in Schedule II in Chapter 34-20B for one period of not more than thirty days, for treatment of causative factors and symptoms. Medications or sample drugs provided to patients shall be accompanied with written administration instructions and appropriate documentation shall be entered in the patient’s medical record;

3. The writing of a chemical or physical restraint order when the patient may do personal harm or harm others;

4. The completion and signing of official documents such as death certificates, birth certificates, and similar documents required by law;

5. The performance of a physical examination for participation in athletics and the certification that the patient is healthy and able to participate in athletics.

Citation: S.D. CODIFIED LAWS § 36-9A-12.

The nurse practitioner or nurse midwife advanced practice nursing functions include:
1. Providing advanced nursing assessment, nursing intervention, and nursing case management;
2. Providing advanced health promotion and maintenance education and counseling to clients, families, and other members of the health care team;
3. Utilizing research findings to evaluate and implement changes in nursing practice, programs, and policies; and
4. Recognizing limits of knowledge and experience, planning for situations beyond expertise, and consulting with or referring clients to other health care providers as appropriate.

These advanced practice nursing functions are under the jurisdiction of the Board of Nursing.

_Citation:_ S.D. _CODIFIED LAWS_ § 36-9A-13.1.

**Tennessee**
There is no description of the scope of practice for a nurse practitioner in Tennessee law, other than the authority to write and sign prescriptions and/or issue drugs.
An advanced practice nurse shall only perform invasive procedures involving any portion of the spine, spinal cord, sympathetic nerves of the spine or block of major peripheral nerves of the spine in any setting not licensed under title 68, chapter 11 under the direct supervision of a Tennessee physician licensed pursuant to chapter 6 or 9 of this title who is actively practicing spinal injections and has current privileges to do so at a facility licensed pursuant to title 68, chapter 11. The direct supervision provided by a physician in this subsection (f) shall only be offered by a physician who meets the qualifications established in § 63-6-241(a)(1) or (a)(3) or § 63-9-119(a)(1) or (a)(3). For purposes of this subsection (f), “direct supervision” is defined as being physically present in the same building as the advanced practice nurse at the time the invasive procedure is performed. This subsection (f) shall not apply to an advanced practice nurse performing major joint injections except sacroiliac injections, or to performing soft tissue injections or epidurals for surgical anesthesia or labor analgesia in unlicensed settings.

Citation: TENN. CODE ANN. §63-7-126(f).
Texas
The advanced practice nurse provides a broad range of health services, the scope of which shall be based upon educational preparation, continued advanced practice experience and the accepted scope of professional practice of the particular specialty area. Advanced practice nurses practice in a variety of settings and, according to their practice specialty and role, they provide a broad range of health care services to a variety of patient populations.

1. The scope of practice of particular specialty areas shall be defined by national professional specialty organizations or advanced practice nursing organizations recognized by the Board. The advanced practice nurse may perform only those functions which are within that scope of practice and which are consistent with the Nursing Practice Act, Board rules, and other laws and regulations of the State of Texas.

2. The advanced practice nurse’s scope of practice shall be in addition to the scope of practice permitted a registered nurse and does not prohibit the advanced practice nurse from practicing in those areas deemed to be
within the scope of practice of a registered nurse.

_Citation:_ 22_ TEX. ADMIN. CODE § 221.12.

_Utah_

“Practice of advanced practice registered nursing” means the practice of nursing within the generally recognized scope and standards of advanced practice registered nursing as defined by rule and consistent with professionally recognized preparation and education standards of an advanced practice registered nurse by a person licensed under this chapter as an advanced practice registered nurse. Advanced practice registered nursing includes:

a. maintenance and promotion of health and prevention of disease;
b. diagnosis, treatment, correction, consultation, and referral for common health problems; and
c. prescription or administration of prescription drugs or devices, including:
   i. local anesthesia
   ii. Schedule III-V controlled substances; and
   iii. Schedule II controlled substances in accordance with Section 58-31b-803.
Vermont

“Advanced practice registered nurse” or “APRN” means a licensed registered nurse, authorized to practice in this state who, because of specialized education and experience, is licensed and authorized to perform acts of medical diagnosis and to prescribe medical, therapeutic, or corrective measures under administrative rules adopted by the Board.

(a) Nurse practitioners providing primary care may be primary care providers of record.

(b) The scope of an APRN includes:

1. registered nurse scope of practice;

2. acts of medical diagnosis including, ordering and interpreting diagnostic tests and procedures;

3. prescribing medications;

4. prescribing medical, therapeutic, or corrective measures;
5. initiating written or verbal orders to other health care providers; and

6. managing and evaluating care.

_Citation:_ VT. BOARD of NURSING ADMIN. RULES 04-030-170 Section 8.5.

**Virginia**
A nurse practitioner licensed in a category other than certified registered nurse anesthetist shall be authorized to render care in collaboration and consultation with a licensed patient care team physician as part of a patient care team.

_Citation:_ 18 VA. ADMIN. CODE § 90-30-120A.

**Washington**
An advanced registered nurse practitioner, under his or her license, may perform for compensation, nursing care, as that term is usually understood, of the ill, injured, or infirm and in the course thereof, she or he may do the following things that shall not be done by a person not so licensed, except as provided in RCW 18.79.260 and 18.79.270:

1. Perform specialized and advanced levels of nursing as recognized jointly by the medical
and nursing professions, as defined by the commission;
2. Prescribe legend drugs and Schedule V controlled substances, as defined in the Uniform Controlled Substances Act, chapter 69.50 RCW, and Schedules II through IV subject to RCW 18.79.240(1)(r) or (s) within the scope of practice defined by the commission;
3. Perform all acts provided in RCW 18.79.260;
4. Hold herself or himself out to the public or designate herself or himself as an advanced registered nurse practitioner or as a nurse practitioner.

_Citation_: WASH. REV. CODE § 18.79.250.

An advanced registered nurse practitioner may sign and attest to any certificates, cards, forms, or other required documentation that a physician may sign, so long as it is within the advanced registered nurse practitioner’s scope of practice.

_Citation_: WASH. REV. CODE § 18.79.256.

The scope of practice of a licensed ARNP is as provided in RCW 18.79.250 and this section.
1. The ARNP is prepared and qualified to assume primary responsibility and accountability for the care of patients.

2. ARNP practice is grounded in nursing process and incorporates the use of independent judgment. Practice includes collaborative interaction with other health care professionals in the assessment and management of wellness and health conditions.

3. The ARNP functions within his or her scope of practice following the standards of care defined by the applicable certifying body as defined in WAC 246-840-302. An ARNP may choose to limit the area of practice within the commission approved certifying body’s practice.

4. An ARNP shall obtain instruction, supervision, and consultation as necessary before implementing new or unfamiliar techniques or practices.

5. Performing within the scope of the ARNP’s knowledge, experience, and practice, the licensed ARNP may perform the following:
   a. Examine patients and establish diagnoses by patient history, physical examination, and other methods of assessment;
b. Admit, manage, and discharge patients to and from health care facilities;
c. Order, collect, perform, and interpret diagnostic tests;
d. Manage health care by identifying, developing, implementing, and evaluating a plan of care and treatment for patients;
e. Prescribe therapies and medical equipment;
f. Prescribe medications when granted authority under this chapter;
g. Refer patients to other health care practitioners, services or facilities; and
h. Perform procedures or provide care services that are within the ARNP’s scope of practice according to the commission approved certifying body as defined in WAC 246-840-302.

Citation: WASH. ADMIN. CODE § 246-840-300.

West Virginia
“Advanced Practice Registered Nurse” (APRN) means a registered nurse who has acquired clinical knowledge and skills preparing him or her to independently provide direct and indirect care to patients, who has completed a board approved
graduate-level education program and who has passed a board approved national certification examination.

_Citation:_ W. VA. Code St. R. tit. 19, § 19-7-2.1.

Whenever any law or rule requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, the signature, certification, stamp, verification, affidavit or endorsement of an advanced practice registered nurse is permitted to have the same force and effect.

_Citation:_ W. VA. Code § 30-7-15d.

**Wisconsin**
The intent of the board of nursing in adopting rules in this chapter is to specify education, training, or experience that a registered nurse must satisfying to call himself or herself an advanced practice nurse; to establish appropriate education, training, and examination requirements that an advanced practice nurse must satisfy to qualify for a certificate to issue prescription orders; to define the scope of practice within which an advanced practice nurse prescriber may issue prescription orders; to specify the classes of drugs, individual drugs, or devices
that may not be prescribed by an advanced practice nurse prescriber; to specify the conditions to be met for a registered nurse to administer a drug prescribed or directed by an advanced practice nurse prescriber; to establish procedures for maintaining a certificate to issue prescription orders, including requirements for continuing education; and to establish the minimum amount of malpractice insurance required of an advanced practice nurse prescriber.

*Citation: WIS. ADMIN. CODE § N8.01(2).*

To promote case management, the advanced practice nurse prescriber 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.

*Citation: WIS. ADMIN. CODE § N8.10(6).*

**Wyoming**

(a) As used in this act:

(i) “Advanced practice registered nurse (APRN)” means a nurse who:
A. May prescribe, administer, dispense or provide nonprescriptive and prescriptive medications including prepackaged medications, except Schedule I drugs as defined in W.S. 35-7-1013 and 35-7-1014;

B. Has responsibility for the direct care and management of patients and clients in relation to their human needs, disease states and therapeutic and technological interventions . . .

_Citation:_ WYO. STAT. ANN. § 33-21-120(a)(i).

(a) Scope and Standards for APRN:

(i) The APRN is subject at all times to the standards and scope of practice established by national professional organizations and/or accrediting agencies representing the various core, role and population focus areas for APRNs, and the NPA.

(ii) The Board recognizes APRN core, role and population focus areas
described in the scope of practice statements for APRNs issued by national professional organizations and/or accrediting agencies.

(iii) Role and population focus of the APRN shall be declared, and the role and population focus to be utilized shall be the title(s) granted by nationally recognized professional organization(s) and/or accrediting agency(ies) or the title(s) of the role and population focus of nursing practice in which the APRN has received postgraduate education preparation.

(iv) In order to practice in one of the four roles and in a defined population, the APRN shall be recognized by the Board in that particular role with a population focus of advanced practice nursing.

(b) Prescriptive Authority:

(i) The Board may authorize an APRN to prescribe medications and devices, within the recognized scope of APRN’s role and population focus, and in accordance with all applicable state
and federal laws including, but not limited to, the WPA, WCSA, the FCSA, and their applicable Rules and Regulations.

*Citation: WYO. BOARD of NURSING RULES* ch. 3, § 2(a), (b).
Appendix 2-B Physician Collaboration

Alabama

COLLABORATION. A formal relationship between one or more certified registered nurse practitioners and certified nurse midwives and a physician or physicians under which these nurses may engage in advanced practice nursing as evidenced by written protocols approved in accordance with the requirements of this article or exempted in accordance with requirements of this article. The term collaboration does not require direct, on-site supervision of the activities of a certified registered nurse practitioner or a certified nurse midwife by the collaborating physician. The term does require such professional oversight and direction as may be required by the rules and regulations of the State Board of Medical Examiners and the Board of Nursing.

Citation: Ala. Code § 34-21-81(5).

Requirements for collaborative practice by physicians and certified registered nurse
practitioners:

1. The collaborating physician shall:
   a. Provide professional medical oversight and direction to the certified registered nurse practitioner.
   b. Be readily available for direct communication or by radio, telephone or telecommunications.
   c. Be readily available for consultation or referrals of patients from the certified registered nurse practitioner.

2. In the event the collaborating physician is not readily available, provisions shall be made for medical coverage by a physician who is pre-approved by the State Board of Medical Examiners and is familiar with these rules.

3. The certified registered nurse practitioner’s scheduled hours in patient homes, facilities licensed by the Alabama Department of Public Health, and facilities certified by the Alabama Department of Mental Health are not subject to the required minimum hours for physician presence.

4. The collaborating physician shall:
   a. Have no additional requirement for documentation of on-site collaboration
when working in the same facility with the certified registered nurse practitioner (CRNP).

b. Be present for not less than ten percent (10%) of the CRNP’s scheduled hours in an approved practice site with a CRNP who has less than two (2) years (4,000 hours) of collaborative practice experience:
   i. Since initial certification; or
   ii. In the collaborating physician’s practice specialty.

c. Visit remote practice sites no less than twice annually.

d. Meet no less than quarterly with the CRNP who has more than two (2) years (4,000 hours) of collaborative practice experience.

e. Allow a pre-approved covering physician to be present in lieu of the collaborating physician.

5. The collaborating physician shall provide notice in writing to the State Board of Medical Examiners of the commencement or termination of a collaborative practice agreement as required by Rule 540-X-8-.04.
6. The Joint Committee may, at its discretion, waive the requirements of written verification of physician availability upon documentation of exceptional circumstances. Employees of the Alabama Department of Public Health and county health departments are exempt from the requirements of written verification of physician availability.

7. A written standard protocol specific to the specialty practice area of the certified registered nurse practitioner and the specialty practice area of the collaborating physician, approved and signed by both the collaborating physician and the certified registered nurse practitioner, shall:
   a. Identify all sites where the certified registered nurse practitioner will practice within the collaboration protocol.
   b. Identify the physician’s principal practice site.
   c. Be maintained at each practice site.
   d. Include a formulary of drugs, devices, medical treatments, tests and procedures that may be prescribed, ordered, and implemented by the certified registered nurse practitioner consistent with these rules and which
are appropriate for the collaborative practice setting.

e. Include a pre-determined plan for emergency services.

f. Specify the process by which the certified registered nurse practitioner shall refer a patient to a physician other than the collaborating physician.

g. Specify a plan for quality assurance management with defined quality outcome measures for evaluation of the clinical practice of the certified registered nurse practitioner and include review of a meaningful sample of medical records plus all adverse outcomes. Documentation of quality assurance review shall be readily retrievable, identify records that were selected for review, include a summary of findings, conclusions, and, if indicated, recommendations for change. Quality assurance monitoring may be performed by designated personnel, with final results presented to the physician and certified registered nurse practitioner for review.

_Citation: ALA. ADMIN. CODE r. 610-X-5-.09._
Alaska

[A]n applicant for initial authorization to practice as an advanced nurse practitioner . . ., if intending to deliver health care services to the public, must submit with the application for initial authorization a consultation and referral plan; the plan must

C. list the applicant’s method of routine consultations and referrals, the method of documenting routine consultations and referrals in the patient record, and the names and titles of health care providers that the applicant will use for routine consultations and referrals;

D. list the applicant’s method for emergency referrals . . .

*Citation:* [Alaska Admin. Code tit. 12, § 44.400(5C&D).*

Arizona

“Collaborate” means to establish a relationship for consultation or referral with one or more licensed physicians on an as-needed basis. Supervision of the activities of a registered nurse practitioner by the collaborating physician is not required.

*Citation:* [Arizona Admin. Code § R4-19-101.*
Arkansas
A collaborative practice agreement shall include, but not be limited to, provisions addressing: (1) The availability of the collaborating physician for consultation or referral or both; (2) Methods of management of the collaborative practice, which shall include protocols for prescriptive authority; (3) Coverage of the health care needs of a patient in the emergency absence of the advanced practice registered nurse or physician; and (4) Quality assurance.

*Citation: ARK. CODE ANN. § 17-87-310(c).*

California
Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing or ordering drugs or devices when all of the following apply:

a. The drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon when the drugs or devices furnished or ordered are consistent with the practitioner’s educational
preparation or for which clinical competency has been established and maintained.

b. The nurse practitioner is functioning pursuant to standardized procedure, as defined by Section 2725, or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator or the designee.

c.

1. The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner’s competence, including peer review, and review of the provisions of the standardized procedure.

2. In addition to the requirements in paragraph (1), for Schedule II controlled substance protocols, the provision for furnishing Schedule II controlled substances shall address the
diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

d. The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner.

e. For purposes of this section, no physician and surgeon shall supervise more than four nurse practitioners at one time.

f. 1. Drugs or devices furnished or ordered by a nurse practitioner may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act . . . and shall be further limited to those drugs agreed upon by the nurse practitioner and physician
and surgeon and specified in the standardized procedure.

2. When Schedule II or III controlled substances . . . are furnished or ordered by a nurse practitioner, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the nurse practitioner’s standardized procedure relating to controlled substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner furnishing the order.

g.

1. The board has certified in accordance with Section 2836.3 that the nurse practitioner has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section.

2. A physician and surgeon may determine the extent of supervision necessary pursuant to this section in
the furnishing or ordering of drugs and devices.

3. Nurse practitioners who are certified by the board and hold an active furnishing number, who are authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration, shall complete, as part of their continuing education requirements, a course including Schedule II controlled substances based on the standards developed by the board. The board shall establish the requirements for satisfactory completion of this subdivision.

h. Use of the term “furnishing” in this section, in health facilities defined in Section 1250 of the Health and Safety Code, shall include (1) the ordering of a drug or device in accordance with the standardized procedure and (2) transmitting an order of a supervising physician and surgeon.

i. “Drug order” or “order” for purposes of this section means an order for medication which
is dispensed to or for an ultimate user, issued by a nurse practitioner as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to “prescription” in this code and the Health and Safety Code shall include drug orders issued by nurse practitioners; and (3) the signature of a nurse practitioner on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

Citation: ANN. CAL. BUS. & PROF. CODE § 2836.1.

Furnishing or ordering of drugs or devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure. All nurse practitioners who are authorized pursuant to Section 2836.1 to furnish or issue drug orders for controlled substances shall
register with the United States Drug Enforcement Administration.

_Citation:_ ANN. CAL. BUS. & PROF. CODE § 2836.2.

**Colorado**

An advanced practice nurse shall practice in accordance with the standards of the appropriate national professional nursing organization and have a safe mechanism for consultation or collaboration with a physician or, when appropriate, referral to a physician. Advanced practice nursing also includes, when appropriate, referral to other health care providers.

_Citation:_ COLO. REV. STAT. ANN. § 12-38-111.5(6).

**Connecticut**

2. An advanced practice registered nurse having been issued a license pursuant to section 20-94a shall, for the first three years after having been issued such license, collaborate with a physician licensed to practice medicine in this state. . . . “[C]ollaboration” means a mutually agreed upon relationship between such advanced practice registered nurse and a physician who is educated, trained, or has relevant experience that is related to the work
of such advanced practice registered nurse. The collaboration shall address a reasonable and appropriate level of consultation and referral, coverage for the patient in the absence of such advanced practice registered nurse, a method to review patient outcomes, and a method of disclosure of the relationship to the patient. Relative to the exercise of prescriptive authority, the collaboration between such advanced practice registered nurse and a physician shall be in writing and shall address the level of Schedule II and III controlled substances that such advanced practice registered nurse may prescribe and provide a method to review patient outcomes, including, but not limited to, the review of medical therapeutics, corrective measures, laboratory tests, and other diagnostic procedures that such advanced practice registered nurse may prescribe, dispense, and administer.

3. An advanced practice registered nurse having (A) been issued a license pursuant to section 20-94a, (B) maintained such license for a period of not less than three years, and (C) engaged in the performance of advanced practice registered nursing activities in collaboration with a physician for a period of
not less than three years and not less than two thousand hours in accordance with the provisions of subdivision (2) of this subsection, may, thereafter, alone or in collaboration with a physician or another health care provider licensed to practice in the state: (i) Perform the acts of diagnosis and treatment of alterations in health status, as described in subsection (a) of this section; and (ii) prescribe, dispense and administer medical therapeutics and corrective measures and dispense drugs in the form of professional samples as described in subdivision (2) of this subsection in all settings. Any advanced practice registered nurse electing to practice not in collaboration with a physician in accordance with the provisions of this subdivision shall maintain documentation of having engaged in the performance of advanced practice level nursing activities in collaboration with a physician for a period of not less than three years and not less than two thousand hours. Such advanced practice registered nurse shall maintain such documentation for a period of not less than three years after completing such requirements and shall submit such documentation to the
Department of Public Health for inspection not later than forty-five days after a request made by the department for such documentation. Any such advanced practice registered nurse shall submit written notice to the Commissioner of Public Health of his or her intention to practice without collaboration with a physician after completing the requirements described in this subdivision and prior to beginning such practice. Not later than December first, annually, the Commissioner of Public Health shall publish on the department’s Internet web site a list of such advanced practice registered nurses who are authorized to practice not in collaboration with a physician.


**Delaware**

Advanced practice nurses shall operate in collaboration with a licensed physician, dentist, podiatrist, or licensed Delaware health-care delivery system to cooperate, coordinate, and consult with each other as appropriate pursuant to a collaborative agreement defined in the rules and regulations promulgated by the Board of Nursing, in the provision of health care to their patients.
Advanced practice nurses desiring to practice independently or to prescribe independently must do so pursuant to § 1906(a)(20) of Title 24.

_Citation:_ Del. Code Ann. tit. 24, § 1902(c)(1).

The Board shall have the authority to grant, restrict, suspend or revoke practice or prescriptive authority and be responsible for promulgating rules and regulations to implement the provisions of this chapter regarding advanced practice registered nurses who have been granted authority for independent practice or prescriptive authority.

_Citation:_ Del. Code Ann. tit. 24, § 1906(a)(20).

Those individuals who wish to engage in independent practice without written guidelines or protocols and/or wish to have independent prescriptive authority shall apply for such privilege or privileges to the Joint Practice Committee and do so only in collaboration with a licensed physician, dentist, podiatrist, or licensed Delaware health-care delivery system. This does not include those individuals who have protocols and/or waivers approved by the Board of Medical Licensure and Discipline.
a. A collaborative agreement must outline how the parties to the agreement will cooperate, coordinate, and consult pursuant to the Board of Nursing’s rules and regulations.

b. All new APRN graduates and those nurses seeking to obtain independent practice must practice under a collaborative agreement for 2 years and a minimum of 4,000 full-time hours.

c. An APRN already practicing pursuant to a collaborative agreement as of July 1, 2015, shall be required to resubmit the collaborative agreement to the Committee, granted credit for any hours accumulated, and required to otherwise comply with the relevant provisions of this chapter in order to obtain independent practice.

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District of Columbia

a. Generally, advanced practice registered nurses shall carry out acts of advanced registered nursing in collaboration with a licensed health care provider.
b. Notwithstanding the provisions of this section, hospitals, facilities, and agencies, in requiring specific levels of collaboration and licensed health care providers in agreeing to the levels of collaboration, shall apply reasonable, nondiscriminatory standards, free of anticompetitive intent or purpose, in accordance with Chapter 14 of Title 2, Chapter 45 of Title 28, and § 44-507.

*Citation: D.C. STAT. § 3-1206.03.*

**Florida**

An Advanced Registered Nurse Practitioner shall only perform medical acts of diagnosis, treatment, and operation pursuant to a protocol between the ARNP and a Florida-licensed medical doctor, osteopathic physician, or dentist. The degree and method of supervision, determined by the ARNP and the physician or dentist, shall be specifically identified in the written protocol and shall be appropriate for prudent health care providers under similar circumstances. General supervision by the physician or dentist is required, unless these rules set a different level of supervision for a particular act. The number of persons to be supervised shall be limited to insure that an acceptable standard of
medical care is rendered in consideration of the following factors:

a. Risk to patient;
b. Educational preparation, specialty, and experience of the parties to the protocol;
c. Complexity and risk of the procedures;
d. Practice setting; and
e. Availability of the physician or dentist.

Citation: FLa. Admin. Code ch. 64B9-4.010(1).

Georgia
A nurse protocol agreement between a physician and an advanced practice registered nurse pursuant to this Code section shall:

1. Be between an advanced practice registered nurse who is in a comparable specialty area or field as that of the delegating physician;
2. Contain a provision for immediate consultation between the advanced practice registered nurse and the delegating physician; if the delegating physician is not available, the delegating physician for purposes of consultation may designate another physician who concurs with the terms of the nurse protocol agreement;
3. Identify the parameters under which delegated acts may be performed by the advanced practice registered nurse, including without limitation the number of refills which may be ordered, the kinds of diagnostic studies which may be ordered, the extent to which radiographic image tests may be ordered, and the circumstances under which a prescription drug order may be executed. In the event the delegating physician authorizes the advanced practice registered nurse to order an X-ray, ultrasound, or radiographic imaging test, the nurse protocol agreement shall contain provisions whereby such X-ray, ultrasound, or radiographic imaging test shall be read and interpreted by a physician who is trained in the reading and interpretation of such tests; a report of such X-ray, ultrasound, or radiographic imaging test may be reviewed by the advanced practice registered nurse; and a copy of such report shall be forwarded to the delegating physician, except that such provision for an ultrasound shall not be required for an advanced practice registered nurse acting within his or her scope of practice as authorized by Code Sections 43-26-3 and 43-26-5.
4. Require documentation either in writing or by electronic means or other medium by the advanced practice registered nurse of those acts performed by the advanced practice registered nurse which are specific to the medical act authorized by the delegating physician;

5. Include a schedule for periodic review by the delegating physician of patient records. Such patient records review may be achieved with a sampling of such records as determined by the delegating physician;

6. Provide for patient evaluation or follow-up examination by the delegating physician or other physician designated by the delegating physician pursuant to paragraph (2) of this subsection, with the frequency of such evaluation or follow-up examination based on the nature, extent, and scope of the delegated act or acts as determined by the delegating physician in accordance with paragraph (3) of this subsection and accepted standards of medical practice as determined by the board;

7. Be reviewed, revised, or updated annually by the delegating physician and the advanced practice registered nurse;
8. Be available for review upon written request to the advanced practice registered nurse by the Georgia Board of Nursing or to the physician by the board; and

9. Provide that a patient who receives a prescription drug order for any controlled substance pursuant to a nurse protocol agreement shall be evaluated or examined by the delegating physician or other physician designated by the delegating physician pursuant to paragraph (2) of this subsection on at least a quarterly basis or at a more frequent interval as determined by the board.

\textit{Citation: GA. CODE ANN. § 43-34-25(c).}

In addition to and without limiting the authority granted pursuant to Code Section 43-34-23, a physician may delegate to an advanced practice registered nurse in accordance with a nurse protocol agreement the authority to order drugs, medical devices, medical treatments, diagnostic studies, or, in life-threatening situations, radiographic imaging tests.

\textit{Citation: GA. CODE ANN. § 43-34-25(b).}

\textbf{Hawaii}
“Collaborate” means a process in which an APRN works with other members of the health care team to deliver health care services.

*Citation:* HAW. ADMIN. R. § 16-89-2.

**Idaho**

An advanced practice registered nurse collaborates with other health professionals in providing health care.

*Citation:* IDAHO CODE § 54-1402(1).

Collaboration means the cooperative working relationship with another health care provider, each contributing his respective expertise in the provision of patient care, and such collaborative practice includes the discussion of patient treatment and cooperation in the management and delivery of health care.

*Citation:* IDAHO ADMIN. CODE § 23.01.01-271(09).

**Illinois**

a. A written collaborative agreement is required for all advanced practice nurses engaged in clinical practice, except for advanced practice nurses who are authorized
to practice in a hospital, hospital affiliate, or ambulatory surgical treatment center.

a-5. If an advanced practice nurse engages in clinical practice outside of a hospital, hospital affiliate, or ambulatory surgical treatment center in which he or she is authorized to practice, the advanced practice nurse must have a written collaborative agreement.

b. A written collaborative agreement shall describe the relationship of the advanced practice nurse with the collaborating physician or podiatric physician and shall describe the categories of care, treatment, or procedures to be provided by the advanced practice nurse. A collaborative agreement with a dentist must be in accordance with subsection (c-10) of this Section.

Collaboration does not require an employment relationship between the collaborating physician or podiatric physician and advanced practice nurse. The collaborative relationship under an agreement shall not be construed to require the personal presence of a physician or podiatric physician at the place where services are rendered. Methods of communication shall be available for consultation with the collaborating
physician or podiatric physician in person or by telecommunications or electronic communications as set forth in the written agreement.

b-5. Absent an employment relationship, a written collaborative agreement may not (1) restrict the categories of patients of an advanced practice nurse within the scope of the advanced practice nurse’s training and experience, (2) limit third party payors or government health programs, such as the medical assistance program or Medicare with which the advanced practice nurse contracts, or (3) limit the geographic area or practice location of the advanced practice nurse in this State.

(d) A copy of the signed, written collaborative agreement must be available to the Department upon request from both the advanced practice nurse and the collaborating physician, dentist, or podiatric physician.

(e) Nothing in this Act shall be construed to limit the delegation of tasks or duties by a physician to a licensed practical nurse, a registered professional nurse, or other persons in accordance with Section 54.2 of
the Medical Practice Act of 1987. Nothing in
this Act shall be construed to limit the method
of delegation that may be authorized by any
means, including, but not limited to, oral,
written, electronic, standing orders, protocols,
guidelines, or verbal orders. Nothing in this
Act shall be construed to authorize an
advanced practice nurse to provide health
care services required by law or rule to be
performed by a physician.

(f) An advanced practice nurse shall inform
each collaborating physician, dentist, or
podiatric physician of all collaborative
agreements he or she has signed and provide
a copy of these to any collaborating
physician, dentist, or podiatric physician upon
request. [ Portions omitted. ]

Citation: 225 ILL. COMP. STAT. § 65/65-35

[ as amended by Public Act 098-0192, enacted
August 6, 2013, scheduled for repeal on January 1,
2018. ]

An advanced practice nurse may provide services in
a hospital or a hospital affiliate . . . or a licensed
ambulatory surgical treatment center without a
written collaborative agreement pursuant to Section 65-35 of this Act.

*Citation:* 225 ILL. COMP. STAT. § 65/65-45(a)

[Scheduled for repeal on January 1, 2018.]

**Indiana**

As used in this section, “practitioner” has the meaning set forth in IC 16-42-19-5. However, the term does not include the following: a veterinarian, an advanced practice nurse, or a physician assistant.

*Citation:* IND. CODE ANN. § 25-23-1-19.4(b).

An advanced practice nurse shall operate in collaboration with a licensed practitioner as evidenced by a practice agreement, or by privileges granted by the governing board of a hospital . . . with the advice of the medical staff of the hospital that sets forth the manner in which an advanced practice nurse and a licensed practitioner will cooperate, coordinate, and consult with each other in the provision of health care to their patients.

*Citation:* IND. CODE ANN. § 25-23-1-19.4(c).
An advanced practice nurse may be authorized to prescribe legend drugs, including controlled substances, if the advanced practice nurse . . . (7) submits proof of collaboration with a licensed practitioner in the form of a written practice agreement that sets forth the manner in which the advanced practice nurse and licensed practitioner will cooperate, coordinate, and consult with each other in the provision of health care to patients. Practice agreements shall be in writing and shall also set forth provisions for the type of collaboration between the advanced practice nurse and the licensed practitioner and the reasonable and timely review by the licensed practitioner of the prescribing practices of the advanced practice nurse.

_Citation:_ IND. ADMIN. CODE tit. 848, r. 5-1-1(7).

**Iowa**

The ARNP may perform selected medically designated functions when a collaborative practice agreement exists.

Collaborative practice agreement means an ARNP and physician practicing together within the framework of their respective professional scopes of practice. This collaborative agreement reflects both independent and cooperative decision making and
is based on the preparation and ability of each practitioner.

_Citation:_ Iowa Admin. Code r. 655-7.1(152).

**Author’s note:** The Iowa Board of Nursing interprets Iowa law as not requiring physician involvement in nurse practitioner practice:

- “In Iowa, an ARNP may practice independently within their specialty area. The Iowa Board of Nursing does not require a collaborative agreement between an ARNP and physician. It is the informal opinion and recommendation of the board that the ARNP establishes professional relationships with physicians to ensure patients/clients receive quality healthcare.”

  _Source:_ Iowa Board of Nursing website.

- “An ARNP may have a collaborative agreement with a physician or physicians if their practice so warrants, but this agreement is not a requirement of the Iowa Board of Nursing.”

  _Source:_ Iowa Board of Nursing Newsletter, Volume 28, Number 4.
Author’s note: The inconsistency between the regulatory language and the Board of Nursing statements seem to be related to whether an ARNP is performing medicine or nursing. Making medical diagnoses and treating with medical therapies (prescribing medications and ordering therapies) are medical functions, and therefore would require collaboration with a physician.

**Kansas**

An advanced practice registered nurse may prescribe drugs pursuant to a written protocol as authorized by a responsible physician. Each written protocol shall contain a precise and detailed medical plan of care for each classification of disease or injury for which the advanced practice registered nurse is authorized to prescribe and shall specify all drugs which may be prescribed by the advanced practice registered nurse. Any written prescription order shall include the name, address, and telephone number of the responsible physician. The advanced practice registered nurse may not dispense drugs, but may request, receive and sign for professional samples and may distribute professional samples to patients pursuant to a written protocol as authorized by a responsible physician.
Each APRN shall be authorized to make independent decisions about advanced practice nursing needs of families, patients, and clients and medical decisions based on the authorization for collaborative practice with one or more physicians.

“Authorization for collaborative practice” shall mean that an APRN is authorized to develop and manage the medical plan of care for patients or clients based upon an agreement developed jointly and signed by the APRN and one or more physicians. Each APRN and physician shall jointly review the authorization for collaborative practice annually. Each authorization for collaborative practice shall include a cover page containing the names and telephone numbers of the APRN and the physician, their signatures, and the date of review by the APRN and the physician. Each authorization for collaborative practice shall be maintained in either hard copy or electronic format at the APRN’s principal place of practice.
Kentucky
Except as authorized by KRS 314.196 and subsection (9) of this section, before an advanced practice registered nurse engages in the prescribing or dispensing of nonscheduled legend drugs as authorized by KRS 314.011(8), the advanced practice registered nurse shall enter into a written “Collaborative Agreement for Advanced Practice Registered Nurse’s Prescriptive Authority for Nonscheduled Legend Drugs” (CAPA-NS) with a physician licensed in Kentucky that defines the scope of the prescriptive authority for nonscheduled legend drugs.

*Citation: KY. REV. STAT. ANN. § 314.042(8)(a).*

Before an advanced practice registered nurse may discontinue or be exempt from a CAPA-NS required under subsection (8) of this section, the advanced practice registered nurse shall have completed four (4) years of prescribing as a nurse practitioner, clinical nurse specialist, nurse midwife, or as a nurse anesthetist. For nurse practitioners and clinical nurse specialists, the four (4) years of prescribing shall be in a population focus of adult-gerontology, pediatrics, neonatal, family, women’s health, acute care, or psychiatric-mental health.
Before an advanced practice registered nurse engages in the prescribing of Schedules II through V controlled substances as authorized by KRS 314.011(8), the advanced practice registered nurse practitioner shall enter into a written “Collaborative Agreement for the Advanced Practice Registered Nurse’s Prescriptive Authority for Controlled Substances” (CAPA-CS) with a physician licensed in Kentucky that defines the scope of the prescriptive authority for controlled substances.

Louisiana
7. “Collaboration” means a cooperative working relationship with licensed physicians, dentists, or other health care providers to jointly contribute to providing patient care and may include, but not be limited to discussion of a patient’s diagnosis and cooperation in the management and delivery of health care with each provider performing those activities that he is legally authorized to perform.
8. “Collaborative practice” means the joint management of the health care of a patient by an advanced practice registered nurse
performing advanced practice registered nursing and one or more consulting physicians or dentists. Except as otherwise provided in R.S. 37:930, acts of medical diagnosis and prescription by an advanced practice registered nurse shall be in accordance with a collaborative practice agreement.

9. “Collaborative practice agreement” means a formal written statement addressing the parameters of the collaborative practice which are mutually agreed upon by the advanced practice registered nurse and one or more licensed physicians or dentists which shall include but not be limited to the following provisions:

   a. Availability of the collaborating physician or dentist for consultation or referral, or both.

   b. Methods of management of the collaborative practice which shall include clinical practice guidelines.

   c. Coverage of the health care needs of a patient during any absence of the advanced practice registered nurse, physician, or dentist.

*Citation: LA. REV. STAT. ANN. § 37:913.*
A. Collaboration is a process in which an APRN has a relationship with one or more physicians or dentists to deliver health care services. Such collaboration is to be evidenced by the APRN scope of practice and indicates the relationships that they have with physicians or dentists to deal with issues outside their scope of practice.

B. APRNs practicing in accord with R.S.37:913(3)(a) are not required to have a collaborative practice agreement. The APRN who engages in medical diagnosis and management shall have a collaborative practice agreement that includes, but is not limited to, the following provisions [R.S. 37:913(8) and (9)]:

1. availability of the collaborating physician or dentist for consultation or referral, or both;
2. methods of management of the collaborative practice which shall include clinical practice guidelines; and
3. coverage of the health care needs of a patient during any absence of the APRN, physician, or both parties.

Citation: LA. ADMIN. CODE tit. 46, § XLVII.4513.
1. Requirements for initial approval to practice
   C. Submits evidence of a minimum of 1500 hours of practice in an expanded specialty nursing role within 5 years preceding application, or have completed a nurse practitioner program within 5 years preceding application. If more than 5 years have elapsed since completion of an advanced practice registered nurse program and the applicant does not meet the practice requirement of 1500 hours, the applicant shall complete 500 hours of clinical practice supervised by a physician or nurse practitioner in the same specialty area of practice.

2. For temporary approval [to practice] for graduates of nurse practitioner programs
   A. A nurse practitioner must practice for a minimum of 24 months under the supervision of a licensed physician, or a supervising nurse practitioner, or be employed by a clinic or hospital that has a medical director who is a licensed physician.
B. The applicant shall identify a supervisory relationship with a licensed physician or nurse practitioner in the same practice category who will provide oversight for the nurse practitioner.

*Citation:* Code Me. R. § 02380008 (Section 2).

**Maryland**

A. A nurse practitioner shall obtain certification from the Board before commencing practice.

B. An applicant for certification as a nurse practitioner shall:
   a. [Identify] a designated mentor for 18 months as defined in Regulation .01 of this chapter; . . .

*Citation:* Md. Code tit. 10, § 27.07.03.

“Mentor” means a certified nurse practitioner or physician, licensed in Maryland, who:

(a) Has 3 or more years of clinical practice experience;

(b) Will be available for advice, consultation, and collaboration, as needed, for 18 months beginning on the date an application is
received by the Board from an applicant who has never been certified in this or any other State.

Citation: Md. Code tit. 10, § 27.07.01B(4).

Massachusetts
Guidelines means written instructions and procedures describing the methods that an APRN with prescriptive practice is to follow when managing medications and that specifies those instances in which referral to or consultation with a physician is required for appropriate medication treatment. When appropriate, guidelines shall also address procedures for the ordering of tests and therapeutics.

Supervising Physician means a physician holding an unrestricted license in Massachusetts who:

(c) provides supervision to a certified nurse practitioner, a certified psychiatric clinical nurse specialist, or certified registered nurse anesthetist, as provided for in the appropriate law or regulations of the Board of Registration in Nursing at 244 CMR 4.07 and the regulations of the Board of Registration in Medicine at 243 CMR 2.10: Advanced
Practice Nurse (APN) Eligible to Engage in Prescriptive Practice;

(d) signs mutually developed and agreed upon prescriptive practice guidelines with the APRN; and

(e) reviews the prescriptive practice of a certified nurse practitioner, certified psychiatric clinical nurse specialist or certified nurse anesthetist as described in the guidelines.

_Citation:_ CODE MASS. REGS. tit. 244, § 4.02.

Except for the CNM who does not require guidelines for prescriptive practice, an APRN engaged in prescriptive practice will do so in accordance with written guidelines mutually developed and agreed upon with the APRN and the physician supervising the APRN’s prescriptive practice.

_Citation:_ CODE MASS. REGS. tit. 244, § 4.07(2)(a).

**Michigan**

Subject to subsections (2) to (6), a licensee who holds a license other than a health profession subfield license may delegate to a licensed or unlicensed individual who is otherwise qualified by
education, training or experience the performance of selected acts, tasks, or functions where the acts, tasks, or functions fall within the scope of practice of the licensee’s profession and will be performed under the licensee’s supervision. A licensee shall not delegate an act, task, or function under this section if the act, task, or function, under standards of acceptable and prevailing practice, requires the level of education, skill, and judgment required of the licensee under this article.

_Citation_: _Mich. Comp. Laws_ § 333.16215(1).

*Note*: House Bill 5400, signed in January 2017, added prescribing of nonscheduled drugs to nurse practitioner scope of practice.

**Minnesota**

“Collaboration” means the process in which two or more health care professionals work together to meet the health care needs of a patient, as warranted by the patient.

_Citation_: _Minn. Stat. Ann._ § 148.171(5a).

**Mississippi**

An advanced practice registered nurse shall perform those functions authorized in this section within a
collaborative/consultative relationship with a dentist or physician with an unrestricted license to practice dentistry or medicine in this state and within an established protocol or practice guidelines, as appropriate, that is filed with the board upon license application, license renewal, after entering into a new collaborative/consultative relationship or making changes to the protocol or practice guidelines or practice site. The board shall review and approve the protocol to ensure compliance with applicable regulatory standards. The advanced practice registered nurse may not practice as an APRN if there is no collaborative/consultative relationship with a physician or dentist and a board approved protocol or practice guidelines.

*Citation: Miss. Nursing Practice Law §73-15-20(3).*

**Missouri**

Collaborative practice arrangements—Refers to written agreements, jointly agreed upon protocols, or standing orders, all of which shall be in writing, for the delivery of healthcare services.

*Citation: Mo. Code Regs. Ann. tit. 20, § 2200-4.200(1)(C).*
A. The collaborating physician in a collaborative practice shall not be so geographically distanced from the collaborating RN or APRN as to create an impediment to effective collaboration in the delivery of healthcare services or the adequate review of those services.

B. The following shall apply in the use of a collaborative practice arrangement by an APRN who provides health care services that include the diagnosis and initiation of treatment for acutely or chronically ill or injured persons:

1. If the APRN is providing services pursuant to section 335.175, RSMo, no mileage limitation shall apply;

2. If the APRN is not providing services pursuant to section 335.175, RSMo, and is practicing in a federally-designated health professional shortage area (HPSA), the practice locations where the collaborating physician, or other physician designated in the collaborative practice arrangement, [are] no further than fifty (50) miles by road, using the most direct route available, from the collaborating APRN;
3. If the APRN is not providing services pursuant to section 335.175, RSMo, and is practicing in a non-HPSA, the collaborating physician and collaborating APRN shall practice within thirty (30) miles by road of one another.

C. An APRN who desires to enter into a collaborative practice arrangement at a location where the collaborating physician is not continuously present shall practice together at the same location with the collaborating physician continuously for a period of at least one (1) month before the collaborating APRN practices at a location where the collaborating physician is not present. It is the responsibility of the collaborating physician to determine and document the completion of the same location practice described in the previous sentence.

D. A collaborating physician shall not enter into a collaborative practice arrangement with more than three (3) full-time equivalent APRNs. This limitation shall not apply to collaborative arrangements of hospital employees providing inpatient care service in hospitals.
as defined in Chapter 197, RSMo, or population-based public health services as defined in this rule.

_Citation:_ Mo. Code Regs. Ann. tit. 20, § 2200-4.200(2).

The methods of treatment and the authority to administer, dispense, or prescribe drugs delegated in a collaborative practice arrangement between a collaborating physician and collaborating APRN shall be within the scope of practice of each professional and shall be consistent with each professional’s skill, training, education, competence, licensure, and/or certification and shall not be further delegated to any person except that the individuals identified in sections 338.095 and 338.198, RSMo, may communicate prescription drug orders to a pharmacist.


C. The collaborating physician shall consider the level of skill, education, training, and competence of the collaborating RN or APRN and ensure that the delegated responsibilities contained in the collaborative practice
arrangement are consistent with that level of skill, education, training, and competence.

D. Guidelines for consultation and referral to the collaborating physician or designated health care facility for services or emergency care that is beyond the education, training, competence, or scope of practice of the collaborating RN or APRN shall be established in the collaborative practice arrangement.

E. The methods of treatment, including any authority to administer or dispense drugs, delegated in a collaborative practice arrangement between a collaborating physician and a collaborating RN shall be delivered only pursuant to a written agreement, jointly agreed-upon protocols, or standing orders that shall describe a specific sequence of orders, steps, or procedures to be followed in providing patient care in specified clinical situations.

F. The methods of treatment, including any authority to administer, dispense, or prescribe drugs, delegated in a collaborative practice arrangement between a collaborating physician and a collaborating APRN shall be delivered only pursuant to a written agreement, jointly agree-upon protocols, or
standing orders that are specific to the clinical conditions treated by the collaborating physician and collaborating APRN.

Citation: MO. CODE REGS. ANN. tit. 20, § 2200-4.200(3).

Methods of treatment delegated and authority to administer, dispense, or prescribe drugs shall be subject to the following:

1. The physician retains the responsibility for ensuring the appropriate administering, dispensing, prescribing, and control of drugs utilized pursuant to a collaborative practice arrangement in accordance with all state and federal statues, rules, or regulations. . . .

Citation: MO. CODE REGS. ANN. tit. 20, § 2200-4.200(3)(G).

A. In order to assure true collaborative practice and to foster effective communication and review of services, the collaborating physician, or other physician designated in the collaborative practice arrangement, shall be immediately available for consultation to
the collaborating RN or APRN at all times, either personally or via telecommunications.

B. The collaborative practice arrangement between a collaborating physician and a collaborating RN or APRN shall be signed and dated by the collaborating physician and collaborating RN or APRN before it is implemented, signifying that both are aware of its content and agree to follow the terms of the collaborative practice arrangement. The collaborative practice arrangement and any subsequent notice of termination shall be in writing and shall be maintained by the collaborating professionals for a minimum of eight (8) years after termination of the collaborative practice arrangement. The collaborative practice arrangement shall be reviewed at least annually and revised as needed by the collaborating physician and collaborating RN or APRN. Documentation of the annual review shall be maintained as part of the collaborative practice arrangement.

C. Within thirty (30) days of any change and with each physician’s license renewal, the collaborating physician shall advise the Missouri State Board of Registration for the Healing Arts whether he/she is engaged in any collaborative practice agreement,
including collaborative practice agreements delegating the authority to prescribe controlled substances and also report to the board the name of each licensed RN or APRN with whom he/she has entered into such agreement. A change shall include, but not be limited to, resignation or termination of the RN or APRN; change in practice locations; and addition of new collaborating professionals.

D. An RN or an APRN practicing pursuant to a collaborative practice arrangement shall maintain adequate and complete patient records in compliance with section 334.097, RSMo.

E. The collaborating physician shall complete a review of a minimum of ten percent (10%) of the total health care services delivered by the collaborating APRN. If the APRN’s practice includes the prescribing of controlled substances, the physician shall review a minimum of twenty percent (20%) of the cases in which the APRN wrote a prescription for a controlled substance. If the controlled substance chart review meets the minimum total ten percent (10%) as described above, then the minimum review requirements have been met. The collaborating APRN’s
documentation shall be submitted for review to the collaborating physician at least every fourteen (14) days. This documentation submission may be accomplished in person or by other electronic means and reviewed by the collaborating physician. The collaborating physician must produce evidence of the chart review upon request of the Missouri State Board of Registration for the Healing Arts. This subsection shall not apply during the time the collaborating physician and collaborating APRN are practicing together as required in subsection (2)(C) above.

F. If a collaborative practice arrangement is used in clinical situations where a collaborating APRN provides health care services that include the diagnosis and initiation of treatment for acutely or chronically ill or injured persons, then the collaborating physician shall be present for sufficient periods of time, at least once every two (2) weeks, except in extraordinary circumstances that shall be documented, to participate in such review and to provide necessary medical direction, medical services, consultations, and supervision of the health care staff. In such settings, the use of a collaborative practice arrangement shall be
limited to only an APRN. If the APRN is providing services pursuant to section 335.175, RSMo, the collaborating physician may be present in person or the collaboration may occur via telehealth in order to meet the requirements of this section. Telehealth providers shall obtain the patient’s or the patient’s guardian’s consent before telehealth services are initiated and shall document the patient’s or the patient’s guardian’s consent in the patient’s file or chart. All telehealth activities must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 and all other applicable state and federal laws and regulations.

G. The collaborating physician and collaborating RN or APRN shall determine an appropriate process of review and management of abnormal test results which shall be documented in the collaborative practice arrangement.

*Citation: Mo. Code Regs. Ann. tit. 20, § 2200-4.200(4).*

Montana
Certified nurse practitioner (CNP) practice means the independent and/or collaborative management of primary and/or acute health care of individuals, families, and communities across settings.

_Citation_: _Mont. Admin. R._ § 24.159.1470(1).

**Nebraska**

Collaboration means a process and relationship in which a nurse practitioner, together with other health professionals, delivers health care within the scope of authority of the various clinical specialty practices.

_Citation_: _Nebr. Rev. Stat._ § 38-2308.

Transition-to-practice agreement means a collaborative agreement between a nurse practitioner and a supervising provider which provides for the delivery of health care through a collaborative practice and which meets the requirements of section 38-2322.

_Citation_: _Nebr. Rev. Stat._ § 38-2314.01.

(2) In order to practice as a nurse practitioner in this state, an individual who holds or has held a license as a nurse practitioner in this
state or in another state shall submit to the department a transition-to-practice agreement or evidence of completion of two thousand hours of practice as a nurse practitioner which have been completed under a transition-to-practice agreement, under a collaborative agreement, under an integrated practice agreement, through independent practice, or under any combination of such agreements and practice, as allowed in this state or another state.

(3)

(a) A transition-to-practice agreement shall be a formal written agreement that provides that the nurse practitioner and the supervising provider practice collaboratively within the framework of their respective scopes of practice.

(b) The nurse practitioner and the supervising provider shall each be responsible for his or her individual decisions in managing the health care of patients through consultation, collaboration, and referral. The nurse practitioner and the supervising provider shall have joint responsibility for the delivery of health care to a
patient based upon the scope of practice of the nurse practitioner and the supervising provider.

(c) The supervising provider shall be responsible for supervision of the nurse practitioner to ensure the quality of health care provided to patients.

(d) In order for a nurse practitioner to be a supervising provider for purposes of a transition-to-practice agreement, the nurse practitioner shall submit to the department evidence of completion of ten thousand hours of practice as a nurse practitioner which have been completed under a transition-to-practice agreement, under a collaborative agreement, under an integrated practice agreement, through independent practice, or under any combination of such agreements or practice, as allowed in this state or another state.

(4) For the purposes of this section:

(a) Supervising provider means a physician, osteopathic physician, or nurse practitioner licensed and
practicing in Nebraska and practicing in the same practice specialty, related specialty, or field of practice as the nurse practitioner being supervised; and

(b) Supervision means the ready availability of the supervising provider for consultation and direction of the activities of the nurse practitioner being supervised within such nurse practitioner’s defined scope of practice.

Citation: NEB. REV. STAT. § 38-2322.

Nevada
There is no requirement for physician collaboration for NP practice in Nevada.

New Hampshire
There is no requirement for physician collaboration for NP practice in New Hampshire.

New Jersey
b. An advanced practice nurse may order medications and devices in the inpatient setting, subject to the following condition:
   1. the collaborating physician and advanced practice nurse shall address
in the joint protocols whether prior consultation with the collaborating physician is required to initiate an order for a controlled dangerous substance;
2. the order is written in accordance with standing orders or joint protocols developed in agreement between a collaborating physician and the advanced practice nurse, or pursuant to the specific direction of a physician;
3. the advanced practice nurse authorizes the order by signing the nurse’s own name, printing the name and certification number, and printing the collaborating physician’s name;
4. the physician is present or readily available through electronic communications;
5. the charts and records of the patients treated by the advanced practice nurse are reviewed by the collaborating physician and the advanced practice nurse within the period of time specified by rule adopted by the Commissioner of Health pursuant to section 13 of P.L.1991, c.377 (C.45:11-52);
6. the joint protocols developed by the collaborating physician and the advanced practice nurse are reviewed, updated and signed at least annually by both parties; and

7. the advanced practice nurse has completed six contact hours of continuing professional education in pharmacology related to controlled substances, including pharmacologic therapy and addiction prevention and management, in accordance with regulations adopted by the New Jersey Board of Nursing. The six contact hours shall be in addition to New Jersey Board of Nursing pharmacology education requirements for advanced practice nurses related to initial certification and recertification of an advanced practice nurse as set forth in N.J.A.C.13:37-7.2.

c. An advanced practice nurse may prescribe medications and devices in all other medically appropriate settings, subject to the following conditions:
   1. the collaborating physician and advanced practice nurse shall address
in the joint protocols whether prior consultation with the collaborating physician is required to initiate a prescription for a controlled dangerous substance;

2. the prescription is written in accordance with standing orders or joint protocols developed in agreement between a collaborating physician and the advanced practice nurse, or pursuant to the specific direction of a physician;

3. the advanced practice nurse writes the prescription on a New Jersey Prescription Blank pursuant to P.L.2003, c.280 (C.45:14-40 et seq.), signs the nurse’s own name to the prescription and prints the nurse’s name and certification number;

4. the prescription is dated and includes the name of the patient and the name, address, and telephone number of the collaborating physician;

5. the physician is present or readily available through electronic communications;

6. the charts and records of the patients treated by the advanced practice nurse
are periodically reviewed by the collaborating physician and the advanced practice nurse;

7. the joint protocols developed by the collaborating physician and the advanced practice nurse are reviewed, updated, and signed at least annually by both parties; and

8. the advanced practice nurse has completed six contact hours of continuing professional education in pharmacology related to controlled substances, including pharmacologic therapy and addiction prevention and management, in accordance with regulations adopted by the New Jersey Board of Nursing. The six contact hours shall be in addition to New Jersey Board of Nursing pharmacology education requirements for advanced practice nurses related to initial certification and recertification of an advanced practice nurse as set forth in N.J.A.C.13:37-7.2.

d. The joint protocols employed pursuant to subsections b. and c. of this section shall conform with standards adopted by the
Director of the Division of Consumer Affairs pursuant to section 12 of P.L.1991, c. 377 (C.45:11–51) or section 10 of P.L.1999, c. 85 (C.45:11–49.2), as applicable.

*Citation*: N.J. STAT. ANN. § 45:11-49.

**New Mexico**

The Certified Nurse Practitioner makes independent decisions regarding the health care needs of the client and also makes independent decisions in carrying out health care regimens.

*Citation*: N.M. ADMIN. CODE § 16.12.2.13.N(1).

The Certified Nurse Practitioner collaborates as necessary with other healthcare providers. Collaboration includes discussion of diagnosis and cooperation in managing and delivering healthcare.

*Citation*: N.M. ADMIN. CODE § 16.12.2.13.N(4).

In accordance with applicable state and federal laws, the Certified Nurse Practitioner who fulfills the following requirements may prescribe and distribute dangerous drugs including controlled substances included in Schedules II through V of the Controlled Substances Act.
Verify 400 hours of work experience in which prescribing dangerous drugs has occurred within the two (2) years immediately preceding the date of the application. Individuals who have not fulfilled this requirement must provide documentation of successful completion of 400 hours of prescribing dangerous drugs in a preceptorship with a licensed CNP, CNS, or physician. The preceptorship must be completed within six (6) months and a letter of authorization will be issued for the duration of the preceptorship.

_Citation:_ N.M. _ADMIN. CODE_ § 16.12.2.13 N(5)(a)(i).

**New York**

i. The practice of registered professional nursing by a nurse practitioner, certified under section six thousand nine hundred ten of this article, may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures within a specialty area of practice, in collaboration with a licensed physician qualified to collaborate in the specialty involved, provided such services are performed in accordance with a written practice agreement and written practice protocols except as permitted by paragraph (b) of this subdivision. The written
practice agreement shall include explicit provisions for the resolution of any disagreement between the collaborating physician and the nurse practitioner regarding a matter of diagnosis or treatment that is within the scope of practice of both. To the extent the practice agreement does not so provide, then the collaborating physician’s diagnosis or treatment shall prevail.

ii. Prescriptions for drugs, devices and immunizing agents may be issued by a nurse practitioner, under this paragraph and section six thousand nine hundred ten of this article, in accordance with the practice agreement and practice protocols except as permitted by paragraph (b) of this subdivision. The nurse practitioner shall obtain a certificate from the department upon successfully completing a program including an appropriate pharmacology component, or its equivalent, as established by the commissioner’s regulations, prior to prescribing under this paragraph. The certificate issued under section six thousand nine hundred ten of this article shall state whether the nurse practitioner has successfully completed such a program or equivalent and is authorized to prescribe under this paragraph.
iii. Each practice agreement shall provide for patient records review by the collaborating physician in a timely fashion but in no event less often than every three months. The names of the nurse practitioner and the collaborating physician shall be clearly posted in the practice setting of the nurse practitioner.

iv. The practice protocol shall reflect current accepted medical and nursing practice. The protocols shall be filed with the department within ninety days of the commencement of the practice and may be updated periodically. The commissioner shall make regulations establishing the procedure for the review of protocols and the disposition of any issues arising from such review.

v. No physician shall enter into practice agreements with more than four nurse practitioners who are not located on the same physical premises as the collaborating physician.

Citation: N.Y. EDUC. LAW, ART. 139, § 6902.3(a).

Notwithstanding subparagraph (i) of paragraph (a) of this subdivision, a nurse practitioner, certified under section sixty-nine hundred ten of this article
and practicing for more than three thousand six hundred hours may comply with this paragraph in lieu of complying with the requirements of paragraph (a) of this subdivision relating to collaboration with a physician, a written practice agreement and written practice protocols. A nurse practitioner complying with this paragraph shall have collaborative relationships with one or more licensed physicians qualified to collaborate in the specialty involved or a hospital, licensed under article twenty-eight of the public health law, that provides services through licensed physicians qualified to collaborate in the specialty involved and having privileges at such institution. As evidence that the nurse practitioner maintains collaborative relationships, the nurse practitioner shall complete and maintain a form, created by the department, to which the nurse practitioner shall attest, that describes such collaborative relationships. For purposes of this paragraph, “collaborative relationships” shall mean that the nurse practitioner shall communicate, whether in person, by telephone or through written (including electronic) means, with a licensed physician qualified to collaborate in the specialty involved or, in the case of a hospital, communicate with a licensed physician qualified to collaborate in the specialty involved and having privileges at such hospital, for the purposes of
exchanging information, as needed, in order to provide comprehensive patient care and to make referrals as necessary. Such form shall also reflect the nurse practitioner’s acknowledgement that if reasonable efforts to resolve any dispute that may arise with the collaborating physician or, in the case of a collaboration with a hospital, with a licensed physician qualified to collaborate in the specialty involved and having privileges at such hospital, about a patient’s care are not successful, the recommendation of the physician shall prevail. Such form shall be updated as needed and may be subject to review by the department. The nurse practitioner shall maintain documentation that supports such collaborative relationships. Failure to comply with the requirements found in this paragraph by a nurse practitioner who is not complying with such provisions of paragraph (a) of this subdivision, shall be subject to professional misconduct provisions as set forth in article one hundred thirty of this title.

Citation: N.Y. Educ. Law, Art. 139, § 6902.3(b).

North Carolina
The following are the quality assurance standards for a collaborative practice agreement:
1. Availability: The primary or back-up supervising physician(s) and the nurse practitioner shall be continuously available to each other for consultation by direct communication or telecommunication.

2. Collaborative Practice Agreement:
   a. shall be agreed upon and signed by both the primary supervising physician and the nurse practitioner, and maintained in each practice site;
   b. shall be reviewed at least yearly. This review shall be acknowledged by a dated signature sheet, signed by both the primary supervising physician and the nurse practitioner, appended to the collaborative practice agreement and available for inspection by members or agents of either Board;
   c. shall include the drugs, devices, medical treatments, tests, and procedures that may be prescribed, ordered and performed by the nurse practitioner consistent with Rule .0809 of this Section; and
   d. shall include a pre-determined plan for emergency services.
3. The nurse practitioner shall demonstrate the ability to perform medical acts as outlined in the collaborative practice agreement upon request by members or agents of either Board.

   a. The primary supervising physician and the nurse practitioner shall develop a process for the ongoing review of the care provided in each practice site including a written plan for evaluating the quality of care provided for one or more frequently encountered clinical problems.
   b. This plan shall include a description of the clinical problem(s), an evaluation of the current treatment interventions, and if needed, a plan for improving outcomes within an identified timeframe.
   c. The quality improvement process shall include scheduled meetings between the primary supervising physician and the nurse practitioner at least every six months. Documentation for each meeting shall:
      i. identify clinical problems discussed, including progress
toward improving outcomes as stated in Sub-item (4)(b) of this Rule, and recommendations, if any, for changes in treatment plan(s);

ii. be signed and dated by those who attended; and

iii. be available for review by members or agents of either Board for the previous five calendar years and be retained by both the nurse practitioner and primary supervising physician.

5. Nurse Practitioner-Physician Consultation. The following requirements establish the minimum standards for consultation between the nurse practitioner and primary supervising physician(s):

a. During the first six months of a collaborative practice agreement between a nurse practitioner and the primary supervising physician, there shall be monthly meetings for the first six months to discuss practice relevant clinical issues and quality improvement measures.
b. Documentation of the meetings shall:
   i. identify clinical issues discussed and actions taken;
   ii. be signed and dated by those who attended; and
   iii. be available for review by members or agents of either Board for the previous five calendar years and be retained by both the nurse practitioner and primary supervising physician.

Citation: N.C. ADMIN. CODE tit. 21, r. § 36.0810.

North Dakota
There is no requirement for physician collaboration for APRN practice in North Dakota.

Ohio
A . . . certified nurse practitioner, in collaboration with one or more physicians or podiatrists, may provide preventive and primary care services, provide services for acute illness, and evaluate and promote patient wellness within the nurse’s nursing specialty, consistent with the nurse’s education and certification, and in accordance with rules adopted by the board. A certified nurse practitioner who
holds a certificate to prescribe issued under Section 4723.48 of the Revised Code may, in collaboration with one or more physicians or podiatrists, prescribe drugs and therapeutic devices in accordance with Section 4723.481 of the Revised Code. When a certified nurse practitioner is collaborating with a podiatrist, the nurse’s scope of practice is limited to the procedures that the podiatrist has the authority under Section 4731.51 of the Revised Code to perform.

_Citation:_ OHIO REV. CODE ANN. § 4723.43(C).

(A) . . . [A] certified nurse practitioner may practice only in accordance with a standard care arrangement entered into with each physician or podiatrist with whom the nurse collaborates. A copy of the standard care arrangement shall be retained on file at each site where the nurse practices. Prior approval of the standard care arrangement by the board of nursing is not required, but the board may periodically review it for compliance with this section.

A . . . certified nurse practitioner may enter into a standard care arrangement with one or more collaborating physicians or podiatrists. Not later than thirty days after first engaging
in the practice of nursing as a . . . certified nurse practitioner, the nurse shall submit to the board the name and business address of each collaborating physician or podiatrist. Thereafter, the nurse shall give to the board written notice of any additions or deletions to the nurse’s collaborating physicians or podiatrists not later than thirty days after the change takes effect.

Each collaborating physician or podiatrist must be actively engaged in direct clinical practice in this state and practicing in a specialty that is the same as or similar to the nurse’s nursing specialty. If a collaborating physician or podiatrist enters into standard care arrangements with more than three nurses who hold certificates to prescribe issued under section 4723.48 of the Revised Code, the physician or podiatrist shall not collaborate at the same time with more than three of the nurses in the prescribing component of their practices.

(B) A standard care arrangement shall be in writing and . . . shall contain all of the following:

(1) Criteria for referral of a patient by the . . . certified nurse practitioner to a
collaborating physician or podiatrist;

(2) A process for the . . . certified nurse practitioner to obtain a consultation with a collaborating physician or podiatrist;

(3) A plan for coverage in instances of emergency or planned absences of either the . . . certified nurse practitioner or a collaborating physician or podiatrist that provides the means whereby a physician or podiatrist is available for emergency care;

(4) The process for resolution of disagreements regarding matters of patient management between the . . . certified nurse practitioner and a collaborating physician or podiatrist;

(5) A procedure for a regular review of the referrals by the . . . certified nurse practitioner to other health care professionals and the care outcomes for a random sample of all patients seen by the nurse;

(6) If the . . . certified nurse practitioner regularly provides services to infants, a policy for care of infants up to age one
and recommendations for collaborating physician visits for children from birth to age three;

(7) Any other criteria required by rule of the board adopted pursuant to section 4723.07 or 4723.50 of the Revised Code.

(C)

(1) A standard care arrangement entered into pursuant to this section may permit a . . . certified nurse practitioner to supervise services provided by a home health agency as defined in section 3701.881 of the Revised Code.

(2) A standard care arrangement entered into pursuant to this section may permit a . . . certified nurse practitioner to admit a patient to a hospital in accordance with section 3727.06 of the Revised Code.

(E) Nothing in this section prohibits a hospital from hiring a . . . certified nurse practitioner as an employee and negotiating standard care arrangements on behalf of the employee as
necessary to meet the requirements of this section. A standard care arrangement between the hospital’s employee and the employee’s collaborating physician is subject to approval by the medical staff and governing body of the hospital prior to implementation of the arrangement at the hospital.

_Citation:_ **OHIO REV. CODE ANN. § 4723.431.**

**Oklahoma**

A Certified Nurse Practitioner shall be eligible, in accordance with the scope of practice of the Certified Nurse Practitioner, to obtain recognition as authorized by the Board to prescribe . . . subject to the medical direction of a supervising physician.

_Citation:_ **OKLA. STAT. ANN. tit. 59, § 567.3a(6).**

The Advanced Practice Registered Nurse applicant for prescriptive authority shall . . . submit a written statement from an Oklahoma-licensed physician supervising prescriptive authority which identifies a mechanism for:

(A) appropriate referral, consultation, and collaboration between the Advanced Practice
Registered Nurse and physician supervising prescriptive authority;

(B) availability of communication between the Advanced Practice Registered Nurse and physician supervising prescriptive authority through direct contact, telecommunications, or other appropriate electronic means for consultation, assistance with medical emergencies or patient referral.

*Citation: OKLA. ADMIN. CODE § 485:10-16-3(3).*

**Oregon**

There is no requirement for physician collaboration for APRN practice in Oregon.

**Pennsylvania**

Collaboration—A process in which a CRNP works with one or more physicians to deliver health care services within the scope of the CRNP’s expertise. The process includes all of the following:

i. Immediate availability of a licensed physician to a CRNP through direct communications or by radio, telephone or telecommunications.

ii. A predetermined plan for emergency services.
iii. A physician available to a CRNP on a regularly scheduled basis for referrals, review of the standards of medical practice incorporating consultation and chart review, drug and other medical protocols within the practice setting, periodic updating in medical diagnosis and therapeutics and cosigning records when necessary to document accountability by both parties.

_Citation: 49 P.A. Code § 21.251._

A CRNP may collaborate only with physicians who hold a current license to practice in this Commonwealth.

_Citation: 49 P.A. Code § 21.282a(a)._  

A CRNP with prescriptive authority may, when acting in collaboration with a physician as set forth in a prescriptive authority collaborative agreement and within the CRNP’s specialty, prescribe and dispense drugs and give written or oral orders for drugs and other medical therapeutic or corrective measures.

_Citation: 49 P.A. Code § 21.283(a)._
Rhode Island
“Certified nurse practitioner” is an advanced practice nurse utilizing independent knowledge of physical assessment, diagnosis, and management of health care and illnesses. The practice includes prescriptive privileges. . . . Certified nurse practitioners may be recognized as the primary care provider or acute-care provider of record.

Citation: R.I. R. § R5-34-NUR/ED 1.0(1.10).

South Carolina
. . . Nurse practitioners who perform delegated medical acts must have a supervising physician or dentist who is readily available for consultation and shall operate within the approved written protocols.

Citation: S.C. CODE ANN. § 40-33-20(41).

“Approved written protocols” mean specific statements developed collaboratively by a physician or the medical staff and a NP, CNM, or CNS that establishes physician delegation for medical aspects of care, including the prescription of medications.

Citation: S.C. CODE ANN. § 40-33-20(10).
1. Delegated medical acts performed by a nurse practitioner, certified nurse-midwife, or clinical nurse specialist must be performed pursuant to an approved written protocol between the nurse and physician and must include . . .
   a. This general information:
      i. Name, address, and South Carolina license number of the nurse;
      ii. Name, address, and South Carolina license number of the physician;
      iii. Nature of practice and practice locations of the nurse and physician;
      iv. Date the protocol was developed and dates the protocol was reviewed and amended;
      v. Description of how consultation with the physician is provided and provision for backup consultation in the physician’s absence.

   b. This information for delegated medical acts:
      i. The medical conditions for which therapies may be initiated,
continued, or modified;

ii. The treatments that may be initiated, continued, or modified;

iii. The drug therapies that may be prescribed;

iv. Situations that require direct evaluation by or referral to the physician.

2. The original protocol and any amendments to the protocol must be reviewed at least annually, dated and signed by the nurse and physician, and made available to the Board for review within seventy-two hours of request. Failure to produce protocols upon request of the board is considered misconduct and subjects the licensee to disciplinary action. A random audit of approved written protocols must be conducted by the board at least biennially.

3. Licensees who change practice settings or physicians shall notify the board of the change within fifteen business days and provide verification of approved written protocols. NPs, CNMs and CNSs who discontinue their practice shall notify the board within fifteen days.
South Dakota
“Collaborative agreement” defined. The term, collaborative agreement, as used in this chapter, means a written agreement authored and signed by the nurse practitioner or nurse midwife and the physician with whom the nurse practitioner or nurse midwife is collaborating. A collaborative agreement defines or describes the agreed upon overlapping scope of advanced practice nursing and medical functions that may be performed, consistent with § 36-9A-12 or 36-9A-13, and contains such other information as required by the boards. A copy of each collaborative agreement shall be maintained on file with and be approved by the boards prior to performing any of the acts contained in the agreement.

Advanced practice nursing and medical functions—Collaborative agreement required. A nurse practitioner or nurse midwife may perform the overlapping scope of advanced practice nursing and medical functions only under the terms of a collaborative agreement with a physician licensed under Chapter 36-4. Any collaborative agreement
shall be maintained on file with the boards. Collaboration may be by direct personal contact, or by a combination of direct personal contact and indirect contact via telecommunication, as may be required by the boards. If the collaborating physician named in a collaborative agreement becomes temporarily unavailable, the nurse practitioner or nurse midwife may perform the agreed upon overlapping scope of advanced practice nursing and medical functions in consultation with another licensed physician designated as a substitute.

*Citation: S.D. Codified Laws § 36-9A-17.*

Collaboration with a licensed physician or physicians. A nurse practitioner or nurse midwife may perform the overlapping scope of advanced practice nursing and medical functions defined in SDCL 36-9A-12 and 36-9A-13, in collaboration with a physician or physicians licensed under SDCL Chapter 36-4. Collaboration by direct personal contact with each collaborating physician must occur no less than twice each month unless it is established in the collaborative agreement that one of the twice monthly meetings may be held by telecommunication. Collaboration with each collaborating physician shall occur at least once per month by direct personal contact.
Direct personal contact. For the purposes of this chapter, the term, direct personal contact, means that both the collaborating physician and the nurse practitioner or nurse midwife are physically present on site and available for the purposes of collaboration. When the collaborating physician is not in direct personal contact with the nurse practitioner or nurse midwife, the physician must be available by telecommunication. If the boards consider additional direct personal contact necessary for a nurse practitioner or nurse midwife, they shall set the terms of that additional collaboration and require inclusion of those terms in that nurse practitioner’s or midwife’s collaborative agreement as a condition for its approval.

Collaboration—Separate practice location. In addition to the required two meetings per month, the collaborating physician must be physically present onsite every ninety days at each practice location. This requirement does not apply to locations where health care services are not routine to the setting, such as patient homes and school health screening events.
Citation: S.D. ADMin. R. § 20:62:03:05.

Tennessee

b.

A. A nurse who has been issued a certificate of fitness as a nurse practitioner pursuant to § 63-7-207 and this section shall file a notice with the board, containing the name of the nurse practitioner, the name of the licensed physician having supervision, control, and responsibility for prescriptive services rendered by the nurse practitioner and a copy of the formulary describing the categories of legend drugs to be prescribed and/or issued by the nurse practitioner. The nurse practitioner shall be responsible for updating this information.

B. The nurse practitioner who holds a certificate of fitness shall be authorized to prescribe and/or issue controlled substances listed in Schedules II, III, IV, and V . . . upon joint adoption of physician supervisory rules concerning controlled substances. . . .
Texas

(c) The advanced practice nurse acts independently and/or in collaboration with the health team in the observation, assessment, diagnosis, intervention, evaluation, rehabilitation, care and counsel, and health teachings of persons who are ill, injured, or infirm or experiencing changes in normal health processes; and in the promotion and maintenance of health or prevention of illness.

(d) When providing medical aspects of care, advanced practice nurses shall utilize mechanisms that provide authority for that care. These mechanisms may include, but are not limited to, protocols or other written authorization. This shall not be construed as requiring authority for nursing aspects of care.

A. Protocols or other written authorization shall promote the exercise of professional judgment by the advanced practice nurse commensurate with his/her education and experience. The degree of detail within protocols/policies/practice
guidelines/clinical practice privileges may vary in relation to the complexity of the situations covered by such protocols, the advanced specialty area of practice, the advanced educational preparation of the individual, and the experience level of the individual advanced practice nurse.

B. Protocols or other written authorization:

   A. should be jointly developed by the advanced practice nurse and the appropriate physician(s);

   B. shall be signed by both the advanced practice nurse and the physician(s);

   C. shall be reviewed and re-signed at least annually;

   D. shall be maintained in the practice setting of the advanced practice nurse; and

   E. shall be made available as necessary to verify authority to provide medical aspects of care.
e. The advanced practice nurse shall retain professional accountability for advanced practice nursing care.

Citation: 21 TEX. ADMIN. CODE § 221.13 (c), (d) & (e).

a. The APRN with full licensure and a valid prescription authorization number shall:

1. order or prescribe only those drugs or devices that are:
   A. authorized by a prescriptive authority agreement or, if practicing in a facility-based practice, authorized by either a prescriptive authority agreement or protocols or other written authorization; and
   B. ordered or prescribed for patient populations within the accepted scope of professional practice for the APRN’s license; and

2. comply with the requirements for chart reviews specified in the prescriptive authority agreement and periodic face to face meetings set forth in the prescriptive authority agreement; or
3. comply with the requirements set forth in protocols or other written authorization if ordering or prescribing drugs or devices under facility-based protocols or other written authorization.

b. Prescription Information. The format and essential elements of a prescription drug order shall comply with the requirements of the Texas State Board of Pharmacy. The following information must be provided on each prescription:

1. the patient’s name and address;
2. the name, strength, and quantity of the drug to be dispensed;
3. directions to the patient regarding taking of the drug and the dosage;
4. the intended use of the drug, if appropriate;
5. the name, address, and telephone number of the physician with whom the APRN has a prescriptive authority agreement or facility-based protocols or other written authorization;
6. address and telephone number of the site at which the prescription drug order was issued;
7. the date of issuance;
8. the number of refills permitted;
9. the name, prescription authorization number, and original signature of the APRN who authorized the prescription drug order; and
10. the United States Drug Enforcement Administration numbers of the APRN and the delegating physician, if the prescription drug order is for a controlled substance.

c. Generic Substitution. The APRN shall authorize or prevent generic substitution on a prescription in compliance with the current rules of the Texas State Board of Pharmacy relating to generic substitution.

d. An APRN may order or prescribe medications for sexually transmitted diseases for partners of an established patient, if the APRN assesses the patient and determines that the patient may have been infected with a sexually transmitted disease. Nothing in this subsection shall be construed to require the APRN to issue prescriptions for partners of patients.

e. APRNs may order or prescribe only those medications that are FDA approved unless done through protocol registration in a United
States Institutional Review Board or Expanded Access authorized clinical trial. “Off label” use, or prescription of FDA-approved medications for uses other than that indicated by the FDA, is permitted when such practices are:

1. within the current standard of care for treatment of the disease or condition; and
2. supported by evidence-based research.

f. The APRN with full licensure and a valid prescriptive authorization number shall cooperate with representatives of the Board and the Texas Medical Board during an inspection and audit relating to the operation and implementation of a prescriptive authority agreement.

Citation: 22 TEx. Admin. Code § 222.4.

(a) The prescriptive authority agreement is a mechanism by which an APRN is delegated the authority to order or prescribe drugs or devices by a physician.

(b) An APRN with full licensure and a valid prescriptive authorization number and a
physician are eligible to enter into or be parties to a prescriptive authority agreement only if the APRN:

(1) holds an active license to practice in this state that is in good standing. For purposes of this chapter, an APRN is in good standing if the APRN’s license and prescriptive authorization number are not encumbered by a disciplinary action;

(2) is not currently prohibited by the Board from executing a prescriptive authority agreement; and

(3) before executing the prescriptive authority agreement, the APRN and the physician disclose to the other prospective party to the agreement any prior disciplinary action by the applicable licensing board.

(c) A prescriptive authority agreement must, at a minimum:

(1) be in writing and signed and dated by the parties to the agreement;

(2) state the name, address, and all professional license numbers of the
parties to the agreement;

(3) state the nature of the practice, practice locations, or practice settings;

(4) identify either:

   (A) the types or categories of drugs or devices that may be ordered or prescribed; or

   (B) the types of categories of drugs or devices that may not be ordered or prescribed;

(5) provide a general plan for addressing consultation and referral;

(6) provide a plan for addressing patient emergencies;

(7) state the general process for communication and the sharing of information between the APRN and the physician related to the care and treatment of patients;

(8) if alternate physician supervision is to be utilized, designate one or more alternate physicians who may:
(A) provide appropriate supervision on a temporary basis in accordance with the requirements established by the prescriptive authority agreement and the requirements of Chapter 157, Subchapter B, Occupations Code; and

(B) participate in the prescriptive authority quality assurance and improvement plan meetings required under §157.0512, Occupations Code;

(9) describe a prescriptive authority quality assurance and improvement plan and specify methods for documenting the implementation of the plan that includes the following:

(A) chart review, with the number of charts to be reviewed determined by the APRN and physician; and

(B) periodic face to face meetings between the APRN and the physician at a location agreed upon by both providers.
(d) The periodic face to face meetings described by subsection (c)(9)(B) of this section must:

(1) include:

(A) the sharing of information relating to patient treatment and care, needed changes in patient care plans, and issues relating to referrals; and

(B) discussion of patient care improvement; and

(2) be documented and occur:

(A) except as provided by subparagraph (B) of this paragraph:

i. at least monthly until the third anniversary of the date the agreement is executed; and

ii. at least quarterly after the third anniversary of the date the agreement is executed, with monthly meetings held between
the quarterly meetings by means of a remote electronic communications system, including video conferencing technology or the internet; or

(B) if during the seven years preceding the date the agreement is executed, the APRN for at least five years was in a practice that included the exercise of prescriptive authority with required physician supervision:

i. at least monthly until the first anniversary of the date the agreement is executed; and

ii. at least quarterly after the first anniversary of the date the agreement is executed, with monthly meetings held between the quarterly meetings by means of a remote electronic communications
system, including video conferencing technology or the internet.

(e) Although a prescriptive authority agreement must include the information specified by this section, the agreement may include other provisions agreed to by the APRN and physician, including provisions that were previously contained in protocols or other written authorization.

(f) The APRN shall participate in quality assurance meetings with an alternate physician if the alternate physician has been designated in the prescriptive authority agreement to conduct and document the meeting.

(g) The prescriptive authority agreement is not required to describe the exact steps that an APRN must take with respect to each specific condition, disease, or symptom.

(h) An APRN who is a party to a prescriptive authority agreement must retain a copy of the agreement until the second anniversary of the date the agreement is terminated.
(i) A party to the prescriptive authority agreement may not by contract waive, void, or nullify any provision of this rule or §157.0512 or §157.0513, Occupations Code.

(j) In the event that a party to a prescriptive authority agreement is notified that the individual has become the subject of an investigation by the respective licensing board, the individual shall immediately notify the other party to the prescriptive authority agreement.

(k) The prescriptive authority agreement and any amendments must be reviewed at least annually, dated, and signed by the parties to the agreement. The prescriptive authority agreement shall be made available to the Board, the Texas Medical Board, or the Texas Physician Assistant Board not later than the third business day after the date of receipt of the request from the respective licensing board.

(l) The prescriptive authority agreement should promote the exercise of professional judgment by the APRN commensurate with the APRN’s education and experience and the relationship between the APRN and the physician.
(m) The calculation under Chapter 157, Occupations Code, of the amount of time an APRN has practiced under the delegated prescriptive authority of a physician under a prescriptive authority agreement shall include the amount of time the APRN practiced under the delegated prescriptive authority of that physician before November 1, 2013.

_Citation: 22 T EX. A D M I N. C O D E § 222.5._

_Utah_

“Consultation and referral plan” means a written plan jointly developed by an advanced practice registered nurse and a consulting physician that permits the advanced practice registered nurse to prescribe schedule II controlled substances in consultation with the consulting physician.

_Citation: U TAH C O D E A NN. § 58-31b-102(5)._  

Except as provided in Subsection (3), an advanced practice registered nurse shall prescribe or administer a Schedule II controlled substance in accordance with a consultation and referral plan.

_Citation: U TAH C O D E A NN. § 58-31b-803(2)._
Except as provided by Subsection 58-31b-502(18), an advanced practice registered nurse may prescribe or administer a Schedule II controlled substance without a consultation and referral plan if the advanced practice registered nurse:

(a) has the lessor of:

i. two years of licensure as a nurse practicing advanced practice registered nursing; or

ii. 2,000 hours of experience practicing advanced practice registered nursing; .

Citation: UTAH CODE ANN. § 58-31b-803(3).

Vermont
“Collaborating provider” as used in this Part means a Vermont APRN or Vermont licensed physician in a formal relationship with an APRN to advise, mentor, and consult. An APRN may have more than one collaborating provider.

Citation: VT. BOARD OF NURSING ADMIN. RULES 04-030-170 Section 8.1(b).
Transition to Practice: Collaborative Provider Agreement.

(a) The first 24 months and 2,400 hours of an APRN’s practice in an initial role and/or population focus must be under a formal agreement with a collaborating provider.

(b) An APRN who obtains a subsequent certification in an additional role and population focus shall have a formal agreement with a collaborating provider for that role and population focus for no fewer than 12 months and 1,600 hours.

(c) An APRN shall maintain signed and dated copies of all collaborative provider agreements as part of the practice guidelines. An APRN required to practice under a collaborative provider agreement may not engage in solo practice in the role and population focus covered by the collaborative provider agreement.

(d) An APRN who completes the collaborative provider agreement shall . . . notify the Board that the requirement has been satisfied.

Citation: VT. BOARD OF NURSING ADMIN. RULES 04-030-170 Section 8.14.
(a) The collaborating provider’s license must be active and unencumbered.

(b) The collaborating provider shall practice in the same role and population focus or specialty as the APRN.

(c) An APRN collaborating provider shall have practiced in the same role and population focus for a minimum of four years.

_Citation:_ VT. BOARD OF NURSING ADMIN. RULES 04-030-170 Section 8.15.

A collaborating provider shall:

(a) review, sign, and date the APRN’s practice guidelines;

(b) serve as an advisor, mentor, and consultant to the APRN;

(c) participate in quality assurance activities.

_Citation:_ VT. BOARD OF NURSING ADMIN. RULES 04-030-170 Section 8.16.

**Virginia**

A nurse practitioner licensed in a category other than certified registered nurse anesthetist shall be
authorized to render care in collaboration and consultation with a licensed patient care team physician as part of patient care team.

Citation: 18 VA. ADMIN. CODE § 90-30-120.A.

A. A nurse practitioner with prescriptive authority may prescribe only within the scope of the written or electronic practice agreement with a patient care team physician.

B. At any time there are changes in the patient care team physician, authorization to prescribe, or scope of practice, the nurse practitioner shall revise the practice agreement and maintain the revised agreement.

C. The practice agreement shall contain the following:

1. A description of the prescriptive authority of the nurse practitioner within the scope allowed by law and the practice of the nurse practitioner.

2. An authorization for categories of drugs and devices within the requirements of § 54.1-2957.01 of the Code of Virginia.

3. The signature of the patient care team physician who is practicing with the nurse practitioner or a clear statement
of the name of the patient care team physician who has entered into the practice agreement.

D. In accordance with § 54.1-2957.01 of the Code of Virginia, a physician shall not serve as a patient care team physician to more than six nurse practitioners with prescriptive authority at any one time.

_Citation:_ 18 VA. _ADMIN. CODE_ § 90-40-90.

“Collaboration” means the communication and decision-making process among members of a patient care team related to the treatment and care of a patient and includes (i) communication of data and information about the treatment and care of a patient, including exchange of clinical observations and assessments, and (ii) development of an appropriate plan of care, including decisions regarding the health care provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing, or studies.

“Practice agreement” means a written or electronic statement, jointly developed by the collaborating patient care team physician(s) and the licensed
nurse practitioner(s) that describes the procedures to be followed and the acts appropriate to the specialty practice to be performed by the licensed nurse practitioner(s) in the care and management of patients. The practice agreement also describes the prescriptive authority of the nurse practitioner, if applicable.

*Citation: 18 VA. ADMIN. CODE § 90-30-10.*

**Washington**
No physician collaboration is required by law for nurse practitioner practice in Washington.

**West Virginia**
The board may, in its discretion, authorize an advanced nurse practitioner to prescribe prescription drugs in accordance with applicable state and federal laws.

*Citation: W. VA. CODE ANN. § 30-7-15(a).*

An advanced practice registered nurse is eligible to apply for full authorization to prescribe drugs after satisfying the following requirements:

Has completed at least two years of practice in a collaborative relationship with a qualified
collaborating health care professional: provided that this requirement does not apply to those nurses who have been granted prescriptive authority more than two years prior to the amendment of this section; . . .

“Collaborative relationship” means a working relationship, structured through a written agreement, in which an applicant may prescribe drugs in collaboration with a qualified collaborating health care professional.

“Qualified collaborating health care professional” means a physician, licensed or authorized to practice in West Virginia and registered to prescribe drugs, including controlled substances, or an advanced practice registered nurse, who is licensed to practice in West Virginia and who has been authorized and registered to prescribe drugs, including controlled substances, for a period of not less than five years preceding entry into a collaborative relationship with an applicant.

Collaborative agreements shall include, but are not limited to, the following:

1. Mutually agreed upon written guidelines or protocols for prescriptive authority as it
applies to the advanced practice registered nurse’s clinical practice;
2. Statements describing the individual and shared responsibilities of the advanced practice registered nurse and the qualified collaborating health care professional;
3. Periodic and joint evaluation of prescriptive practice; and
4. Periodic and joint review and updating of the written guidelines or protocols.

Citation: W. Va. Code Ann. § 30-7-15(b).

Wisconsin
Advanced practice nurse prescribers shall facilitate collaboration with other health care professionals, at least one of whom shall be a physician, through the use of modern communication techniques.

Citation: Wis. Admin. Code § N8.10(2).

Advanced practice nurse prescribers shall work in a collaborative relationship with a physician. The collaborative relationship is a process in which an advanced practice nurse prescriber is working with a physician, in each other’s presence when necessary, to deliver health care services within the scope of the practitioner’s professional expertise.
The advanced practice nurse prescriber and the physician must document this relationship.

*Citation: WIS. ADMIN. CODE § N8.10(7).*

**Wyoming**
There is no requirement for physician collaboration or supervision.
Chapter 3: State Regulation of Nurse Practitioner Practice

The law governing nurse practitioner (NP) definition, scope of practice, prescriptive authority, and requirement of physician collaboration, if any, may be enacted by a state legislature in great detail or in general terms. Alternatively, the state legislature may give authority to a licensing board to make the rules and regulations that govern NPs.

The state board that is likely to have the authority to make the rules regarding NPs is the board of nursing. In many states, the board of nursing makes the rules governing NP practice. In some states, however, the board of medicine has a role. See Appendix 3-A for a state-by-state list of the agencies that regulate NPs.

How Laws About NP Practice Evolve
State law takes two forms: statutes and regulations (sometimes referred to as rules). The legislature makes statutory law, and state agencies, under the executive branch of government, make regulations. Regulations cannot contradict statutes but often expand upon the statutes to include more detail of government administration.

When a member of the public wants to change a statute, the advocate must enlist the help of a state legislator, who can introduce a bill that will change the current statute. When a member of the public wants to change a regulation, the advocate must either convince the state agency that is responsible for the regulation to change the regulation or convince a legislator to introduce a bill that, if enacted, would override the regulation.

When an agency decides to change a regulation, the agency writes a new regulation, publishes the regulation in an official state publication, and invites comments from interested parties. The agency may or may not make changes to the proposed regulation based on comments received from interested parties. A proposed regulation becomes a final regulation—law—after it has been published in proposed form and comments have been reviewed. Final regulations are republished, in final form, in
What Is Regulated?
Much of the state law governing NPs appears in regulations; some law is statutory. The practice issues that come under state regulation are:

- Requirements for licensure
- Scope of practice
- Prescriptive authority
- Requirement of collaboration or supervision
- Basis for license suspension, revocation, or nonrenewal
- Reimbursement under Medicaid
- Reimbursement by indemnity insurers
- Requirements of educational programs
- Standards of practice

Licensure Requirements
State law governs the requirements for holding a professional license in the state. All states require NPs to hold state licenses as registered nurses (RNs). Forty states require NPs to have master’s degrees. Forty-five states require NPs to have obtained national certification. Appendix 3-B lists state-by-state requirements for holding and maintaining an NP license.
Basis for Loss of License

State law, usually a regulation, specifies the criteria under which an NP’s license may be revoked, suspended, or not renewed. Examples of some state laws follow. North Carolina makes continuation of practice contingent upon following the rules of physician supervision. Rhode Island’s law does not address physician collaboration or supervision but is concerned with practice-related safety issues.

More specific than most, North Carolina’s law enforces the requirement of an NP to practice under physician supervision:

. . . [A]ction may be taken . . . if one or more of the following is found:

- That the nurse practitioner held himself or herself out or permitted another to represent the nurse practitioner as a licensed physician;
- That the nurse practitioner has engaged or attempted to engage in the performance of medical acts other than according to the collaborative practice agreement.

Citation: N.C. ADMIN. CODE tit. 21, r. 36.0812.

In Rhode Island, grounds for revocation/suspension include:
a. Guilty of fraud or deceit in procuring or attempting to procure a license to practice nursing
b. Guilty of a crime of gross immorality
c. Unfit or incompetent by reason of negligence or habits
d. Habitually intemperate or . . . addicted to one of the habit-forming drugs
e. Mentally incompetent
f. Guilty of unprofessional conduct which includes:
   i. Abandonment of a patient
   ii. Willfully making and filing false reports or records in the practice of nursing
   iii. Willful omission to file reports or record nursing records or reports as required by law
   iv. Failure to furnish appropriate details of client’s nursing needs to succeeding nurse legally qualified to provide continuing nursing services to a client
   v. Willful disregard of standards and failure to maintain standards of the nursing profession
   vi. Failure to comply with the provisions of RIGL§5-34-40(c)(2) of the General Laws, as an Advanced Practice Registered Nurse
g. Guilty of willfully or repeatedly violating any of the provisions of the act and/or the rules and regulations adopted thereunder.

*Citation:* R.I. *Nursing Rules* § 12.1.
Appendix 3-A: State-by-State List of Agencies That Regulate Nurse Practitioners

ALABAMA: State Board of Medical Examiners and Board of Nursing

ALASKA: Board of Nursing

ARIZONA: Board of Nursing

ARKANSAS: Board of Nursing

CALIFORNIA: Board of Registered Nursing

COLORADO: Board of Nursing

CONNECTICUT: Board of Examiners for Nursing

DELAWARE: Board of Nursing and Board of Medical Licensure and Discipline

DISTRICT OF COLUMBIA: Board of Nursing

FLORIDA: Board of Nursing and Board of Medicine

GEORGIA: Board of Nursing
HAWAII: Board of Nursing
IDAHO: Board of Nursing
ILLINOIS: Board of Nursing
INDIANA: Board of Nursing
IOWA: Board of Nursing
KANSAS: Board of Nursing
KENTUCKY: Board of Nursing
LOUISIANA: Board of Nursing
MAINE: Board of Nursing
MARYLAND: Board of Nursing
MASSACHUSETTS: Board of Registration in Nursing
MICHIGAN: Board of Nursing
MINNESOTA: Board of Nursing
MISSISSIPPI: Board of Nursing
MISSOURI: Board of Nursing
MONTANA: Board of Nursing
NEBRASKA: Board of Advanced Practice Registered Nurses
NEVADA: Board of Nursing
NEW HAMPSHIRE: Board of Nursing
NEW JERSEY: Board of Nursing
NEW MEXICO: Board of Nursing
NEW YORK: Board of Nursing
NORTH CAROLINA: Board of Nursing and Medical Board
NORTH DAKOTA: Board of Nursing
OHIO: Board of Nursing
OKLAHOMA: Board of Nursing
OREGON: Board of Nursing
PENNSYLVANIA: Board of Nursing
RHODE ISLAND: Board of Nurse Registration and Nursing Education
SOUTH CAROLINA: Board of Nursing
SOUTH DAKOTA: Board of Nursing and Board of Medical and Osteopathic Examiners
TENNESSEE: Board of Nursing
TEXAS: Board of Nursing
UTAH: Board of Nursing
VERMONT: Board of Nursing
VIRGINIA: Board of Nursing and Board of Medicine

WASHINGTON: Nursing Commission

WEST VIRGINIA: Board of Examiners for Registered Professional Nurses

WISCONSIN: Board of Nursing

WYOMING: Board of Nursing
Appendix 3-B: State-by-State Nurse Practitioner Qualifications Required by Law

All qualifications specified are for initial licensure to practice. For requirements for renewal, check the website of your state’s board of nursing.

Alabama

- Alabama RN license
- Graduation from an organized program of study and clinical experience beyond the basic educational preparation as a registered nurse that prepares nurse practitioners and is recognized by the Board of Nursing and/or the appropriate specialty certifying agency
- Master’s degree or higher in advanced practice nursing from an accredited program recognized by the Board
- Certification as a certified registered nurse practitioner from a national certifying agency recognized by the Board of Nursing in the clinical specialty consistent with educational preparation and appropriate to the area of practice
Alaska
Requirements for initial authority to practice:

- A formal accredited graduate educational course of study in nursing that is a minimum of one academic year in length; prepares registered nurses to perform an expanded role in the delivery of health care; includes a combination of classroom instruction and a minimum of 500 separate, non-duplicated hours of supervised clinical practice; and if completed on or after January 1, 1998, has distinct course offerings of three graduate credits or more in advanced pathophysiology, advanced pharmacotherapeutics, and advanced physical assessment

- Alaska RN license
- Certification as a nurse practitioner by a national certifying agency in the population focus of nursing for which the applicant was educated

Requirement to maintain authority to practice:

- 30 contact hours of continuing education in the population focus of the nurse practitioner every two years

Citation: ALASKA ADMIN. CODE tit. 12, § 44.400.
Arizona

A. An applicant for certification as an advanced practice registered nurse, shall:

1. Hold a current Arizona registered nurse (RN) license in good standing or an RN license in good standing from a compact party state with multistate privileges

2. Submit a verified application to the Board on a form provided by the Board that provides
   a. Full legal name and all former names
   b. Current mailing address and telephone number
   c. Place and date of birth
   d. RN license number, application for RN license, or copy of a multistate compact RN license
   e. Social security number
   f. Current e-mail address
   g. Educational background . . .
   h. Role and population focus . . .
   i. Current employer or practice setting . . .
   j. Evidence of national certification or recertification as an advanced practice registered nurse in the
role and population focus, if applicable, of the application . . .
[additional requirements omitted]

*Citation:* ARIZ. ADMIN. CODE R4-19-505(1) and (2).

A. The Board shall authorize an RNP to prescribe and dispense (P&D) drugs and devices within the RNP’s population focus only if the RNP does all of the following:

1. Obtains authorization by the Board to practice as a registered nurse practitioner;
2. Applies for prescribing and dispensing privileges on the application for registered nurse practitioner certification;
3. Submits a completed verified application on a form provided by the Board that contains all of the following information:
   a. Name, address, e-mail address and home telephone number;
   b. Arizona registered nurse license number, or copy of compact license;
   c. Nurse practitioner population focus;
d. Nurse practitioner certification number issued by the Board; and

e. Business address and telephone number;

4. Submits evidence of a minimum of 45 contact hours of education within the three years immediately preceding the application, covering one or both of the following topics consistent with the population focus of education and certification:
   a. Pharmacology, or
   b. Clinical management of drug therapy, and

5. Submits the required fee.

*Citation: ARIZ. ADMIN. CODE R4-19-511.*

**Arkansas**

- Evidence of education approved by the board
- National certification approved by the board in the advanced practice registered nurse role and population foci appropriate to the educational preparation

*Citation: ARK. CODE ANN. § 17-87-302.*
California

- RN license in California
- One of the following:
  1. Successful completion of a program of study that conforms to the board standards; or
  2. Certification by a national or state organization whose standards are equivalent to those set forth in Section 1484; or
  3. A nurse who has not completed a nurse practitioner program which meets board standards as specified in Section 1484, shall provide:
     A. Documentation of remediation of areas of deficiency in course content and/or clinical experience, and
     B. Verification by a nurse practitioner and by a physician who meet the requirements for faculty members specified in Section 1484(c), of clinical competence in the delivery of primary health care

Citation: CAL. CODE REGS. § 1482.

Colorado
- Completion of an appropriate graduate degree as determined by the board
- National certification from a nationally recognized agency, as determined by the board, in the appropriate role and population focus

For prescriptive authority, in addition to the two conditions above:

- Satisfactory completion of specific educational requirements in the use of controlled substances and prescription drugs, as established by the board, either as part of a degree program or in addition to a degree program
- Professional liability insurance
- A signed attestation stating that at least three years of combined clinical work experience as a professional nurse or as an advanced practice nurse have been completed

*Citation:* COLO. REV. CODE ANN. § 12-38-111.5 and 111.6.

**Connecticut**

- RN license
- Certification as a nurse practitioner from a national certifying body approved by the Board
- 30 hours of education in pharmacology for advanced nursing practice
- Graduate degree in nursing or in a related field recognized for certification as a nurse practitioner from an accredited program recognized by the Board

\textit{Citation: Conn. Gen. Stat. Ann. § 20-94a(a).}

**Delaware**

- RN license in Delaware or a compact state
- Possess a master’s degree or post-basic program certificate in a clinical nursing specialty with national certification that is recognized by the Board

\textit{Citation: Del. Admin. Code tit. 24, §1902(b).}

**District of Columbia**

- RN license
- Submit evidence of national certification or recertification, as applicable, by the ANCC or other national certifying body approved by the Board.
- Furnish proof . . . that the applicant has successfully completed a post-basic nursing education program applicable to the area of practice approved by the Board or accredited by a nationally recognized body accepted by the Board and which is relevant to the nurse practitioner’s area of practice.
Receive a passing score on the national certification examination, offered by the ANCC or any other nationally recognized body accepted by the Board.

*Citation:* D.C. MUNICIPAL RULES tit. 17, §5903.5 and 5904.1.

### Florida
- RN license
- Certification by an appropriate specialty board
- Graduation from a program leading to a master’s degree in a nursing clinical specialty area with preparation in specialized practitioner skills.

*Citation:* F LA. S TAT. ch. 464.012(1).

- Applicant shall submit proof of national advanced practice certification from an approved nursing specialty board
- Pursuant to Section 456.048, F.S., all ARNP’s shall carry malpractice insurance or demonstrate proof of financial responsibility

*Citation:* F LA. A D M I N. C O D E ch. 64B9-4.002(2)&(5).

### Georgia
- RN license in Georgia
- Official transcript which verifies graduation with a master’s or higher degree in nursing for the
respective nurse practitioner specialty or a graduate level post-master’s certificate in an advanced practice registered nurse practitioner specialty and evidence of advanced pharmacology within the curriculum or as a separate course, advanced physical assessment, and pathophysiology

- Verification of current national certification from the respective Board-recognized certifying organization

- The applicant must document one of the following within the four (4) years immediately preceding the date of current application:
  
  a. 500 hours of practice as an advanced practice registered nurse;

  b. graduation from a nursing education program or a graduate level post-master’s certificate in an advanced practice registered nurse practitioner specialty;

  c. completion of a Georgia Board-approved advanced practice registered nurse reentry/refresher program.

*Citation:* GA. COMP. R. & REGS. § r.410-11-.03(3) and (4).

**Hawaii**
- A current, unencumbered RN license in the state of Hawaii
- Unencumbered RN license in all other states where licensed
- An unencumbered license as an advanced practice registered nurse or similar designation in all other states in which the nurse has a current and active license as an advanced practice registered nurse
- Completed an accredited graduate-level education program preparing the nurse for one of the four recognized advanced practice registered nurse roles
- A current, unencumbered certification of having passed a national certification examination that measures roles and population-focused competencies and is recognized by the board
- Maintained continued competencies through recertification in role and population-focused competencies through a national certification program recognized by the board
- Acquired advanced clinical knowledge and skills preparing the nurse to provide direct care to patients through a significant educational and practical concentration on the direct care of patients
- Demonstrated a greater breadth of knowledge, a greater synthesis of data, greater complexity of
skills and interventions, and greater role autonomy than demonstrated by a registered nurse

- Been educationally prepared to assume responsibility and accountability for health promotion and maintenance and to assess, diagnose, and manage patient problems through the use and prescription of pharmacologic and nonpharmacologic interventions
- Acquired clinical experience of sufficient depth and breadth to reflect the intended license

*Citation: HAW. Rev. Stat. Ann. § 457-8.5a.*

- . . . [T]he applicant for recognition as an advanced practice registered nurse shall provide proof of:
  - Documentation relating to any disciplinary action ordered by or pending before any board of nursing in any state or jurisdiction of the United States; and
  - Documentation . . . regarding any criminal conviction . . . within the past twenty years, in which the conviction was not annulled or expunged. . . .

*Citation: HAW. Admin. R. § 16-89-83.*

The requirements for prescriptive authority are as follows:
- Completed application for prescriptive authority for controlled or noncontrolled substances provided by the board and submitted with all appropriate documents and required feeds
- Proof of a current, unencumbered license as a RN
- Proof of a current, unencumbered recognition or license as an advanced practice registered nurse
- Proof of successful completion of an accredited graduate-level nursing program with a significant educational and practical concentration on the direct care of patients, recognized by the board, leading to a master’s degree
- Proof of successful completion of at least 30 contact hours, as part of a master’s degree program from an accredited, board-recognized college or university, of advanced pharmacology education, including advanced pharmacotherapeutics that is integrated into the curriculum, within the three-year time period immediately preceding the date of application
- Payment of a fee

Citation: HAW. ADMIN. R. § 16-89-119.

Idaho

- RN license in Idaho
- Completion of an approved advanced practice registered nursing education program that meets the board requirements for the role of advanced nursing practice for which the applicant is seeking licensure.
- Passed a qualifying examination recognized by the board and have current certification from a national organization recognized by the board.
- Be of sufficiently sound physical and mental health as will not impair or interfere with the ability to practice nursing.

_Citation:_ **IDAHO CODE § 54-1409.**

To prescribe pharmacologic and non-pharmacologic agents:

- Currently licensed as an advanced practice registered nurse in Idaho.
- Evidence of completion of thirty (30) contact hours of post-basic education in pharmacotherapeutics obtained as part of study within a formal educational program or continuing education program, which are related to the applicant’s advanced practice category scope of practice.
- Submit a completed, notarized application form provided by the Board.
- Remit fees prescribed in Section 901.
Illinois

- RN license
- Successful completion of requirements needed to practice as, and hold a current, national certification as a . . . nurse practitioner . . . from the appropriate national certifying body as determined by rule of the Department
- Obtained a graduate degree appropriate for national certification in clinical advanced practice nursing specialty or a graduate degree or post-master’s certificate from a graduate level program in a clinical advanced practice nursing specialty
- Have not violated the provisions of this Act concerning the grounds for disciplinary action
- Submit to the criminal history records check . . .

Indiana

- RN license in Indiana
- Completed a graduate program offered by a college or university accredited by the Commission on Recognition of Postsecondary Accreditation which prepares the registered nurse to practice as a nurse practitioner and

Citation: 225 ILL. COMP. STAT. § 65/65-5(b).
meets the requirements of section 6 of this rule; or

- Completed a certificate program offered by a college or university accredited by the Commission on Recognition of Postsecondary Accreditation which prepares the registered nurse to practice as a nurse practitioner and meets the requirements of section 6 of this rule. Nurse practitioners who complete a certificate program must be certified and maintain certification as a nurse practitioner by a national organization which requires a national certifying examination

  Citation: Ind. Admin. Code tit. 848, r. 4-1-4.

To prescribe:

- Submits an application with the required fee
- Active, unrestricted registered nurse license
- Proof of having met the requirements of all applicable laws for practice as an advanced practice nurse in the state of Indiana
- Baccalaureate or higher degree in nursing
- Completion of a graduate level pharmacology course consisting of at least two semester hours of academic credit from a college accredited by the Commission on Recognition of Postsecondary Accreditation, or
- Completion of 30 hours of continuing education in the past two years, including a minimum of at least eight actual contact hours of pharmacology
- Submits proof of collaboration with a licensed practitioner in the form of a written practice agreement that sets forth the manner in which the advanced practice nurse and licensed practitioner will cooperate, coordinate, and consult with each other in the provision of health care to patients.

*Citation: IND. ADMIN. CODE tit. 848, r. 5-1-1.*

**Iowa**

- RN license in Iowa or from another state that is recognized for licensure in Iowa
- Graduation from a program leading to a master’s degree in a nursing clinical specialty area with preparation in specialized practitioner skills as approved by the board; or satisfactory completion of a formal advanced practice educational program of study in a nursing specialty area approved by the board and appropriate clinical experience as approved by the board
- Copy of the time-dated, advanced level certification by appropriate national certifying body evidencing that the applicant holds current certification in good standing
Copy of official transcript directly from formal advanced practice educational program maintaining the records necessary to document that all requirements have been met in one of the specialty areas of nursing practice.

Citation: IOWA ADMIN. CODE r. 655-7.2(4) and 655-7.2(5).

**Kansas**

Advanced practice registered nursing is based on knowledge and skills acquired in basic nursing education, licensure as a registered nurse and graduation from or completion of a master’s or higher degree in one of the advanced practice registered nurse roles approved by the board of nursing.

Citation: KAN. STAT. § 65-1130(c) (2).

- Completion of a formal, post-basic nursing education program located or offered in Kansas, approved by the board and that prepares the nurse to function in the advanced role for which application is made; or
- Completion of a formal, post-basic nursing education that is not located or offered in Kansas but is determined by the board to meet the
standards for program approval established by K.A.R. 60-17-101 through 60-17-108; or

- Completion of a formal, post-basic nursing education program that could be no longer in existence but is determined by the board to meet standards at least as stringent as those required for program approval by the board at the time of graduation; or

- Hold a current license to practice as an advanced practice registered nurse in the role for which application is made and that meets the following criteria: was issued by a nursing licensing authority of another jurisdiction; and required completion of a program meeting standards equal to or greater than those established by K.A.R. 60-17-101 through 60-17-108; or

- Completion of a formal educational program of post-basic study and clinical experience that can be demonstrated by the applicant to have sufficiently prepared the applicant for practice in the role of advanced practice for which application is made

- Each applicant for a license as an advanced practice registered nurse in a role other than anesthesia or midwifery shall meet one of the following requirements:
1. Have met one of the requirements of subsection (a) before July 1, 1994;
2. If none of the requirements in subsection (a) have been met before July 1, 1994, meet one of the requirements of subsection (a) and hold a baccalaureate or higher degree in nursing; or
3. If none of the requirements in subsection (a) have been met before July 1, 2002, meet one of the requirements of subsection (a) and hold a master’s or higher degree in a clinical area of nursing.

- A license may be granted if an individual has been certified by a national nursing organization whose certification standards have been approved by the board as equal to or greater than the corresponding standards established by the board for obtaining a license to practice as an advanced practice registered nurse.
- Completion of 3 college hours each in advanced pharmacology, advanced pathophysiology, and advanced health assessment or their equivalents.
- If an applicant for a certificate of qualification as an advanced registered nurse practitioner has not gained 1000 hours of advanced nursing practice during the five years preceding the date of application, [they] shall be required to
successfully complete a refresher course as defined by the board.

_Citation:_ KAN. ADMIN. REGS. § 60-11-103.

**Kentucky**

- RN licensure or holding the privilege to practice as a registered nurse in this state and maintain current certification by the appropriate national organization or agency recognized by the board
- Completion of an organized post-basic program of study and clinical experience acceptable to the board
- Certification by a national established organization or agency recognized by the board
- Facility with English language

_Citation:_ KY. REV. STAT. ANN. § 314.042(1)&(2).

**Louisiana**

- RN license in Louisiana and there are no grounds for disciplinary proceedings
- Completion of a minimum of a graduate degree with a concentration in the respective advanced practice nursing role and population focus or completion of a post master’s concentration in the respective advanced practice nursing role and population focus from a program accredited
by a nursing or nursing related accrediting body that is . . . approved by the board

- Submission of evidence of current certification in the respective advanced practice nursing role and population focus by a nationally recognized certifying body approved by the board.

*Citation: L.A. Admin. Code* tit. 46, § XLVII.4507(A)(1).

To prescribe:

- Unencumbered, unrestricted, and valid RN licensure with no pending disciplinary proceedings
- APRN licensure
- Evidence of 500 hours of practice as a licensed ARNP or APRN applicant within 1 year in the clinical specialty for which applicant was educationally prepared immediately prior to applying for prescriptive and distributing authority
- Minimum of 45 contact hours of education (three credit hour academic course) in advanced pharmacotherapeutics
- Minimum of 45 contact hours (three credit hour academic course) in physiology/pathophysiology
- Collaborative practice agreement with one or more licensed collaborating physicians
Each year, six contact hours of continuing education in pharmacotherapeutics

*Citation: LA. ADMIN. CODE tit. 46, § XLVII.4513.*

**Maine**

- RN license in Maine
- Successfully completed a formal education program that is acceptable to the board in an advanced nursing specialty area
- Holds a current certification credential for advanced nursing from a national certifying body whose certification program is acceptable to the board

*Citation: CODE ME. R. 32 M.R.S.A. § 2201-A.*

- A registered professional nurse who is approved by the Board to practice as an advanced practice registered nurse prior to January 1, 1996 is considered to have met the requirements of 32 M.R.S.A. Section 2201-A(2) and (3) regarding education and certification
- As of January 1, 2006, an applicant for initial approval as an advanced practice registered nurse in Maine must hold a master’s degree with preparation in the specialty area for which application is made

*Citation: CODE ME. R. § 02-380-008 (Section 1)(2).*
Submit evidence of current certification in the specialty area of practice, if applicable

Submit evidence of a minimum of 1500 hours of practice in an expanded specialty nursing role within 5 years preceding application, or has completed a nurse practitioner program within 5 years preceding application. If more than 5 years have elapsed since completion of an advanced practice registered nurse program and the applicant does not meet the practice requirement of 1500 hours, the applicant shall complete 500 hours of clinical practice supervised by a physician or nurse practitioner in the same specialty area of practice

Submit evidence of satisfactory completion of 45 contact hours (or 3 credits) of pharmacology . . .

Citation: CODE ME. R. § 02-380-008 (Section 2)(2).

1. Requirements for prescriptive authority for certified nurse practitioners and certified nurse-midwives

   A. If the applicant has not prescribed drugs within the past 2 years, the applicant shall provide evidence of satisfactory completion of 15 contact hours of pharmacology within the 2 years prior to applying for approval to practice.
B. If the applicant has not prescribed drugs within the past 5 years, the applicant shall provide evidence of satisfactory completion of 45 contact hours (or 3 credits) of pharmacology within the 2 years prior to applying for approval to practice.

2. Provision for certified nurse practitioners and certified nurse-midwives with prescriptive authority in other U.S. jurisdictions
   A. A certified nurse practitioner or certified nurse-midwife who holds prescriptive authority in another U.S. jurisdiction must submit evidence of the following:
      1. Minimum of 200 hours of practice in an expanded specialty role within the preceding 2 years.
      2. 45 contact hours (or 3 credits) of pharmacology equivalent to the requirements set forth in Section 64(3)(A) and (B).

B. If the applicant has not prescribed drugs within the past 2 years, the applicant shall provide evidence of satisfactory completion of 15 contact hours of pharmacology within the
2 years prior to applying for approval to practice.

C. If the applicant has not prescribed drugs within the past 5 years, the applicant shall provide evidence of satisfactory completion of 45 contact hours (or 3 credits) of pharmacology within the 2 years prior to applying for approval to practice.

*Citation: CODE ME. R. § 02 380 008 (Section 6).*

**Maryland**

- Hold a current RN license in good standing in Maryland or a compact state
- Submit to the Board documentation that the applicant has graduated from a Board-approved educational program for nurse practitioners
- Submit to the Board documentation of certification as a nurse practitioner by a national certifying body recognized by the Board

*Citation: MD. REGS. CODE 10 § 27.07.03.*

**Massachusetts**

- Valid RN license in Massachusetts in good standing
- Good moral character as required by MGL c. 112, § 74 and as established by Board policy
- Graduation from a graduate degree program designed to prepare the graduate for practice as a certified nurse practitioner that is approved by a national accrediting organization for academic programs acceptable to the Board
- Successful completion of, at minimum, core content at the graduate level in advanced assessment, advanced pathophysiology and advanced pharmacotherapeutics
- Current certified nurse practitioner certification granted by Board-recognized certifying organization

*Citation: Code Mass. Regs. tit. 244, § 4.05(3).*

Registered nurses who apply for initial authorization in advanced nursing practice shall furnish to the board documentation that they have received either a degree for preparation in advanced nursing practice from a graduate school approved by a national accrediting body acceptable to the board, or have received a certificate of completion of an educational program in advanced nursing practice approved by a national accrediting body acceptable to the board. The applicant shall also submit to the board documentation of current certification in advanced nursing practice from a national professional or specialty certifying organization acceptable to the board.
Michigan

- Current and valid RN license in Michigan
- Meets the advanced practice certification standards of one of the certification organizations listed in MICH. ADMIN. CODE R338.10404(3)(c)

Citation: MICH. ADMIN. CODE R338.10404(3).

Minnesota

- Hold a current Minnesota professional nursing license or demonstrate eligibility for licensure as a registered nurse in this state
- Must not hold an encumbered license as a registered nurse in any state or territory
- Have completed a graduate level APRN program accredited by a nursing or nursing-related accrediting body that is recognized by the United States Secretary of Education or the Council for Higher Education Accreditation as acceptable to the board. The education must be in one of the four APRN roles for at least one population focus
- Currently certified by a national certifying body recognized by the board in the APRN role and population foci appropriate to educational preparation
The board shall issue a license to an applicant who does not meet the education requirements in subdivision 1a, paragraph (c), clause (3), if the applicant:

- is recognized by the board to practice as an advanced practice registered nurse in this state on July 1, 2014; and
- meets the requirements under subdivision 1a, paragraph (c), clauses (1), (2), (4), (5), and (6)

Mississippi

- RN license
- Satisfactory completion of a formal post-basic educational program of at least one academic year, the primary purpose of which is to prepare nurses for advanced or specialized practice
- Graduation from a program leading to a master’s or post-master’s degree in a nursing clinical specialty area with a preparation in specialized practitioner skills
- Certification by a board approved certifying body

Citation: Miss. Nursing Practice Law § 73-15-20(1).
Missouri

- Current unencumbered RN license in Missouri or a compact state
- Evidence of completion of appropriate advanced nursing education program
- Current certification in [appropriate] advanced nursing clinical specialty area [from] a MSBN-approved nationally-recognized certifying body
- Evidence of satisfactory, active, up-to-date certification/recertification/maintenance and/or continuing education/competency status

For prescribing:

- Completion of three graduate credit hours of pharmacology offered by an accredited college or university within the last 5 years prior to the date of application to the board
- Evidence of a minimum of 800 hours of clinical practice in the advanced practice nursing clinical specialty area within two years prior to date of application to the board

For prescribing controlled substances:

- Completion of an advanced pharmacology course (45 units that shall include preceptorial experience in the prescription of drugs,
medicines, and therapeutic devices with a qualified preceptor)

- Provide evidence of completion of at least 300 clock hours of preceptorial experience in the prescription of drugs, medicines, and therapeutic devices with a qualified preceptor
- Has had controlled substance prescriptive authority delegated in a collaborative practice agreement under section 334.104, RSMo, with a Missouri licensed physician who has an unrestricted federal Drug Enforcement Administration (DEA) number

*Citation: Mo. Code Regs. tit. 20, CSR 2200-4.100(2) (B).*

**Montana**

- A person licensed under this chapter who holds a certificate in a field of advanced practice registered nursing may practice in the specified field of advanced practice registered nursing upon approval by the board of an amendment to the person’s license granting a certificate in a field of advanced practice registered nursing. The board shall grant a certificate in a field of advanced practice registered nursing to a person who submits written verification of certification by a board-approved national certifying body appropriate to the specific field of advanced
practice registered nursing and who meets any other qualification requirements that the board prescribes.

*Citation: Mont. Code Ann. § 37-8-409(1).*

- Current RN license in Montana or from a compact state
- The applicant shall request that an official transcript, from an accredited graduate-level education program, be sent to the board directly from the applicant’s APRN program to verify the date of completion and degree conferred
- The applicant shall submit evidence of preceptorship (if not shown on transcript)
- The applicant shall submit a copy of current national certification in APRN role and population focus, congruent with education preparation

*Citation: Mont. Admin. R. § 24.159.1412.*

**Nebraska**

- RN license in Nebraska or from an approved compact state
- Evidence of having successfully completed a graduate-level program in the clinical specialty area of nurse practitioner practice, which
program is accredited by a national accrediting body

- Evidence of having successfully completed 30 contact hours of education in pharmacotherapeutics
- Proof of having passed an examination pertaining to the specific nurse practitioner role in nursing adopted or approved by the board with the approval of the department

  Citation: NEB. REV. STAT. § 38-2317(1).

Nevada

- Hold an RN license in Nevada
- Within two years of applying for a license, completion of a program designed to prepare an advanced practice registered nurse that is:
  
  i. at least one academic year in length, which must include, without limitation, didactic instruction and clinical experience with a qualified physician or advanced practice registered nurse;
  
  ii. accredited or approved by an organization approved by the Board;
  
  iii. includes advanced courses in the assessment of health of patients, pathophysiology, and preparation for practice as an advanced practice registered nurse;
iv. includes a concentration of courses for preparation in a specific role or population focus;
v. includes clinical experience that requires the student to integrate the knowledge and skills that are taught in the program and emphasizes the specific role and population focus chosen by the student; and
vi. includes training in making clinical decisions, including, but not limited to, diagnosing health conditions and appropriate care

- If the above academic and clinical training was not completed within two years of the application, then complete 1000 hours of practice, without the privilege of writing prescriptions, under the supervision of a qualified physician or advanced practice registered nurse.
- If previously licensed or certified as an advanced practice registered nurse in another state or jurisdiction, have maintained the licensure or certification in good standing and complied with the requirements for continuing education of that state or jurisdiction.
If the applicant completes a program designed to prepare an advanced practice registered nurse on or after July 1, 1992, but before June 1, 2005:

1. Be certified as an advanced practice registered nurse by a nationally recognized certification agency; and
2. Hold a bachelor’s degree in nursing from an accredited school.

If the applicant completes a program designed to prepare an advanced practice registered nurse on or after June 1, 2005, but before July 1, 2014, hold a master’s or doctorate degree in nursing.

If the applicant completes a program designed to prepare an advanced practice registered nurse on or after July 1, 2014:

1. Hold a master’s or doctorate degree in nursing; and
2. Be certified as an advanced practice registered nurse by the American Board of Nursing Specialties, the National Commission for Certifying Agencies of the Institute for Credentialing Excellence or any other nationally recognized certification agency approved by the Board.
New Hampshire

- Current and unencumbered RN license from New Hampshire or a compact state
- Completion of an accredited advanced nursing education program that includes:
  a. At least 225 hours of theoretical nursing content; and
  b. At least 480 hours of clinical nursing practice, including precepted experience and pharmacological interventions;
- Submission of a final, official transcript from a nurse practitioner program, accredited by a national accrediting body, that demonstrates that the applicant earned a:
  a. Graduate or post-masters graduate degree; or
  b. Certificate prior to July 1, 2004;
- Documentation from the director of the program identified pursuant to (2) above for each pharmacology course taken but not reflected on the transcript, verifying integration of pharmacological interventions;
- Evidence of competence to practice, as a result of participation in and completion of the nurse
practitioner program.

- The following, if the applicant graduated from an APRN program 2 or more years prior to the submission of the application:
  
  a. A copy of current national certification pursuant to Nur 302.04(a)(6);
  
  b. Documentation of meeting the advanced practice requirements set forth in Nur 302.04(a)(6); and
  
  c. Documentation of completion of the continuing education required pursuant to Nur 302.04(a)(7) including at least 5 hours in pharmacology, within the 2 years immediately preceding the application.

_Citation:_ N.H. CODE ADMIN. R. ANN. [NUR] § 301.03(b).

New Jersey

- Current New Jersey RN license in good standing.
- Within two years prior to submitting an application, complete a master’s degree in nursing from a school accredited by a nursing accrediting association recognized by the U.S. Department of Education or a master’s degree in nursing and completed a post-master’s program that focuses on an advanced practice nursing specialty from a school accredited by a nursing
accrediting association recognized by the U.S. Department of Education

- Completion of at least 39 hours in pharmacology
- Completion of six contact hours in pharmacology related to controlled dangerous substances, including pharmacologic therapy and addiction prevention and management
- Pass an advanced practice examination in his/her area of specialty offered by a national certifying agency that is accredited by the American Board of Nursing Specialties and/or the National Commission for Certifying Agencies.

Citation: N.J. ADMIN. CODE tit. 13, § 37:7.1-7.4.

New Mexico

- Current, unencumbered RN license from New Mexico or a compact state
- Successful completion of a master’s degree or higher in a nursing program designed for the education and preparation of nurse practitioners as providers of primary, or acute, or chronic, or long-term, or end of life health care, offered through an accredited institution of higher education or through the armed services
- Applicants who do not hold a master’s level or higher degree from a nurse practitioner program and were initially licensed by any board before
January 1, 2001, must provide verification of NP licensure
- National certification as a nurse practitioner

* Citation: N.M. Admin. Code § 16.12.2.13.A.

To prescribe:

- 400 hours of work experience in which prescribing dangerous drugs has occurred within the two (2) years immediately preceding date of application
- Current state controlled substances registration and current DEA number
- Maintain a formulary of dangerous drugs and controlled substances that may be prescribed

* Citation: N.M. Admin. Code § 16.12.2.13.N(5)(a) and (b).

**New York**

- Possess a valid RN license in New York
- Completion of an educational program registered by the Department of Education . . . which is designed and conducted to prepare graduates to practice as a nurse practitioner, or
- Certification as NP by a national certifying body acceptable to the Department
- At least 3 semester hours in pharmacology in an acceptable NP program or after other educational requirements for certification as a NP have been satisfied

  Citation: N.Y. COMMISSIONER’S REGULATION § 64.4.

North Carolina

- Unrestricted license to practice as RN or compact state
- Successful completion of a nurse practitioner education program as outlined in NCAC tit. 21, § 36.0805
- Certified as a nurse practitioner by a national credentialing body
- Beginning January 1, 2005 all registered nurses seeking first-time nurse practitioner registration in North Carolina shall hold a master’s degree or higher in Nursing or related field with primary focus on Nursing; have successfully completed a graduate-level nurse practitioner education program accredited by a national accrediting body; and certification by nationally credentialing body.

  Citation: N.C. ADMIN. CODE tit. 21, § 36.0803.

North Dakota
Current and unencumbered RN license in North Dakota or compact state

Completion of an accredited graduate level APRN program in one of the four roles and with at least one population focus

Current certification by a national nursing certifying body in the APRN role and population foci appropriate to educational preparation

Certify that scope of practice is consistent with the applicant’s nursing education and nursing certification

_Citation:_ N.D. _Admin. Code_ § 54-05-03.1-04.

To prescribe:

- Licensed as an advanced practice registered nurse in North Dakota
- Submit a notarized prescriptive authority application and pay the fee
- Submit a completed transcript with degree posted from an accredited graduate level advanced practice registered nurse program and which includes evidence of completion of advanced pharmacotherapy, physical assessment, and pathophysiology
- Evidence of completion of contact 30 hours of education or equivalent in pharmacotherapy related to specialty area, which has been
obtained within a three-year period of time immediately prior to the date of application for prescriptive authority, or approved by the board.

* Citation: N.D. ADMIN. CODE § 54-05-03.1-09. 

**Ohio**

- RN license
- Earned a graduate degree with a major in a nursing specialty or a related field that qualifies the applicant to sit for the certification examination of a national certifying organization approved by the board
- Passed the certification examination of a national certifying organization approved by the board . . . to examine and certify . . . nurse practitioners

* Citation: OHIO REV. CODE ANN. § 4723.41. 

**Oklahoma**

- Successful completion of an advanced practice registered nursing education program in preparation for one of four recognized advanced practice registered nurse roles
- Nationally certified as an advanced practice registered nurse by body recognized by board of nursing
- Acquired advanced clinical knowledge and skills in preparation for providing both direct and indirect care to patients, with a significant component of the education focus on direct care of individuals.

  Citation: Okla. Stat. Ann. tit. 59, § 567.3a(5).

Effective January 1, 2016 all applicants for initial licensure or licensure by endorsement as a certified nurse practitioner must hold a graduate level degree from an advanced practice education program accredited by or holding pending approval or candidacy status with the NLN Accreditation Commission or the Commission on Collegiate Nursing Education.


- Current RN license in Oklahoma
- Completion of an advanced practice nursing education program in one of the four advanced practice registered nurse roles (CNP, CNM, CNS, and CRNA) and a specialty recognized by the Board. Effective January 1, 2016 the applicant shall have completed an accredited graduate level advanced practice registered nursing education program in at least one of the following population foci: family/individual across
the lifespan, adult-gerontology (acute and/or primary), neonatal, pediatrics (acute and/or primary), women’s health/gender related, or psychiatric/mental health

*Citation:* OKLA. ADMIN. CODE § 485:10-15-4.

**Oregon**

- Unencumbered RN license in Oregon
- Master’s or doctorate degree in nursing accredited by a national nursing organization recognized by the US Department of Education
- Satisfactory completion of an NP program specific to the role and role population focus for which application is made, and that meets the practice requirements of OAR 851-050-0001
- Meet the practice requirement of OAR 851-050-0004.
- As of January 1, 2011 provide verification of current accredited national board certification from a Nurse Practitioner national certification examination which meets criteria in OAR 851-050-0008, congruent with a Board recognized nurse practitioner role and population focus.

*Citation:* OR. ADMIN. § R. 851-050-0002.

- Completion of a nurse practitioner program within the past year; or within the past two years
and a minimum of 192 hours of practice as a nurse practitioner; or 960 hours of nurse practitioner practice within the five years preceding certification application or renewal; or completion of a Board-supervised advanced practice re-entry program within two years immediately preceding issuance of certification under a limited or registered nurse license and a limited nurse practitioner certificate.

- Initial applicants must provide documentation of a minimum of 384 hours of registered nurse practice, which includes assessment and management of clients and is not completed as an academic clinical requirement or continuing education program. The applicant shall verify completion of the required hours before issuance of the nurse practitioner certificate. This requirement shall be waived for individuals practicing in the specialty area as a licensed certified nurse practitioner in another state for at least 384 hours in the advanced practice role. All practice hours claimed are subject to audit and disciplinary action for falsification.

_Citation:_ [OR. ADMIN. R. § 851-050-0004](https://www.relibrary.org/).

**Pennsylvania**

- Current unrestricted license as a professional nurse in Pennsylvania
Completion of an accredited, Board-approved master’s or postmaster’s nurse practitioner program or other Board-approved program that awarded an advanced degree or a course of study considered by the Board to be equivalent to that required for certification in this Commonwealth at the time the course was completed

National certification in the specialty in which the nurse is seeking certification

A CRNP who holds an unrestricted certification to practice may apply for certification in an additional specialty if they meet the educational and National certification requirements for the specialty

Citation: 49 P.A. CODE § 21.271.

a. A CRNP with prescriptive authority may, when acting in collaboration with a physician as set forth in a prescriptive authority collaborative agreement within the CRNP’s specialty, prescribe and dispense drugs and give written or oral orders for drugs and other medical therapeutic or corrective measures. These orders may include:

1. Orders for drugs, total parenteral nutrition and lipids, in accordance with § 21.284 and 21.285 (related to
prescribing and dispensing parameters; and prescriptive authority collaborative agreements).

2. Disposables and devices adjunctive to a treatment plan.

b. To obtain prescriptive authority approval, a CRNP shall:
   1. Successfully complete at least 45 hours of course work specific to advanced pharmacology in accordance with the following:
      i. The course work in advanced pharmacology may be either part of the CRNP education program or, if completed outside of the CRNP education program, an additional course or courses taken from an educational program or programs approved by the Board.
      ii. The course work in advanced level above a pharmacology course required by a professional nursing (RN) education program.
      iii. The course work shall have been completed within 5 years
immediately preceding the date the applicant applies for initial prescriptive authority approval.

2. Submit an application for prescriptive authority approval to the Board.
3. Pay the fee set forth in § 21.253 (relating to fees).

c. A CRNP who has prescriptive authority shall complete at least 16 hours of Board-approved continuing education in pharmacology in the two years prior to the biennial renewal date of the certification. The CRNP shall verify completion of the continuing education when submitting a biennial renewal.

Citation: 49 P.A. Code §21.283.

Rhode Island

- Current RN license in Rhode Island or privilege to practice and shall not hold an encumbered license or privilege to practice as an RN in any state or territory
- Completion of an accredited graduate or post-graduate level APRN program in one of the three roles (RNP, CRNA, CNS) and at least one population focus
Currently certified by a national certifying body recognized by the board of nursing in the APRN role and population foci appropriate to educational preparation

* Citation: R.I.R. § R5-34-45(a). *

To prescribe:

- Completion of 30 hours of education in pharmacology within 3 years prior to application

To maintain prescriptive privileges:

- Completion of 30 hours of continuing education in pharmacology every six years

* Citation: R.I.R. § R5-34-NUR/ED 10.3 and 10.3(1). *

**South Carolina**

- RN license in South Carolina
- Current specialty certification by a board-approved credentialing organization. New graduates shall provide evidence of certification within one year of program completion.
- Master’s degree in nursing from an accredited college or university
- Declared specialty area of nursing practice and the specialty title to be used must be the title
which is granted by the board-approved credentialing organization

To prescribe:

- 45 contact hours of education in pharmacotherapeutics within two years before application
- At least 15 hours of education in controlled substances

*Citation: S.C. Code Ann. § 40-33-34(A).*

**South Dakota**

- RN license in South Dakota
- Completion of an approved program for the preparation of Nurse Practitioners
- Passed an examination that the boards in their discretion may require

*Citation: S.D. Codified Laws § 36-9A-4.*

**Tennessee**

- Tennessee licensed RN who has a master’s degree or higher in a nursing specialty and has national specialty certification as a nurse practitioner

*Citation: Tenn. Comp. R. & Regs. tit. 11, ch. 1000-4-.02(1).*
- Current unencumbered license as an RN in Tennessee
- Completed preparation in advanced practice nursing at the post-basic professional nursing level and holds a master’s degree or higher in a nursing specialty. A master’s degree or higher in a nursing specialty is not required if: National certification in a nursing specialty and licensure in Tennessee as a registered nurse was obtained prior to July 1, 2005, or national certification in a nursing specialty and licensure as a registered nurse with the multistate licensure privilege to practice in Tennessee was obtained prior to July 1, 2005
- Current national specialty certification in the appropriate nursing specialty area

_Citation:_ TENN. COMP. R. & REGS. tit. 11, ch. 1000-4-.03.

**Texas**

- Current, valid, unencumbered license or privilege to practice as a registered nurse in Texas
- Graduation from a graduate level advanced practice registered nurse educational program accredited by a national nursing education accrediting body that is recognized by the U.S. Department of Education and the Board.
- Completed a minimum of 400 hours of current practice within the last 24 calendar months in the advanced practice role and population-focus area for which the applicant is applying unless the applicant has completed an advanced practice registered nursing educational program in this advanced practice role and population-focus area within the last 24 calendar months.

- Obtained 20 contact hours of continuing education within the last 24 calendar months appropriate for the advanced practice role and population-focus area for which the applicant is applying. Continuing education in the advanced practice role and population-focus area must meet the requirements of Chapter 216 of this title.

- Current certification in an advanced nursing role and population-focus area recognized by the Board that is congruent with the advanced practice nursing educational preparation.

_Citation: 22 Texas Admin. Code § 221.4._

For prescriptive authority:

- Full licensure from the Board to practice as an advanced practice registered nurse.

- Have successfully completed courses in pharmacotherapeutics, advanced pathophysiology, advanced health assessment,
and diagnosis and management of disease and conditions within the role and population focus area

_Citation:_ 22 TExAS A_dmin. C ode § 222.2.

**Utah**

- Be in a condition of physical and mental health that will allow the applicant to practice safely as an advanced practice registered nurse
- Current RN license in good standing in Utah
- Graduate degree in advanced practice registered nursing or a related area of specialized knowledge as determined appropriate by the division in collaboration with the board
- Successful completion of course work in patient assessment, diagnosis and treatment, and pharmacotherapeutics from an education program approved by the division in collaboration with the board
- Passing of examinations as required by division rule made in collaboration with the board
- Certification by a program approved by the division in collaboration with the board

_Citation:_ UTAH C ode A nn. § 58-31b-302(4).

**Vermont**
- RN license
- Have a degree or certificate from a Vermont graduate nursing program approved by the Board or a United States graduate program approved by a state or a national accrediting agency that includes a curriculum substantially equivalent to Vermont programs approved by the Board. The educational program shall meet the educational standards set by the national accrediting board and the national certifying board. Programs shall include a supervised clinical component in the role and population focus of the applicant’s certification. The program shall prepare nurses to practice advanced nursing in a role as a nurse practitioner . . . and shall include, at a minimum, graduate level courses in: advanced pharmacotherapeutics, advanced patient assessment, and advanced pathophysiology
- Hold current advanced nursing certification in a role and population focus granted by a national certifying organization recognized by the Board

_Citation:_ 26 V.S.A. § 028-002-1611.

**Virginia**
- Current, active RN license in Virginia or a current multistate licensure privilege as an RN
- Graduate degree in nursing or in the appropriate nurse practitioner specialty from an educational program designed to prepare nurse practitioners that is an approved program as defined in 18VAC90-30-10
- Evidence of professional certification consistent with specialty area by an agency accepted by the boards

  Citation: 18 VA. ADMIN. CODE § 90-30-80A.

For prescriptive authority:

- Current, unrestricted license as a nurse practitioner
- Evidence of conditioned professional certification as a nurse practitioner, or
- Completion of a graduate-level course in pharmacology or pharmacotherapeutics as part of NP program within five years prior to submission of the application, or
- Practice as NP for no less than 1000 hours and 15 continuing education units related to the area of practice for each of the two years prior to submission of the application, or
- Thirty hours of education in pharmacology or pharmacotherapeutics acceptable to the boards taken within five years prior to submission of the application. The 30 contact hours may be
obtained in a formal academic setting as a discrete offering or as noncredit continuing education offerings and shall include the following course content: Applicable federal and state laws; prescription writing; drug selection, dosage, and route; drug interactions; information resources; and clinical application of pharmacology related to specific scope of practice

- Practice agreement between NP and patient care team physician

Citation: 18 V.A. ADMIN. CODE § 90-40-40.

Washington
An active Washington state RN license, without sanctions or restrictions

- A graduate degree from an advanced nursing education program accredited by a national nursing accreditation body recognized by the United States Department of Education
- Certification from a certifying body as identified in WAC 246-840-302
- Advanced clinical practice hours: Either initiate the ARNP application process within one year of earning a graduate degree from an advanced nursing education program, or complete one hundred twenty-five hours of advanced clinical
practice, supervised by an ARNP, a physician . . ., or an osteopathic physician, for each additional year following graduation, not to exceed one thousand hours

_Citation:_ **WASH. Admin. Code** § 246-840-340(1),(3)& (4).

For prescriptive authority:

- Current license as an ARNP in Washington that is not subject to sanctions or restrictions issued by the commission
- Evidence of completion of 30 contact hours of education in pharmacotherapeutics within two-year time period immediately prior to application date for prescriptive authority. . . .

_Citation:_ **WASH. Admin. Code** § 246-840-410.

**West Virginia**

- RN license, in good standing, in West Virginia
- Satisfactorily completed a graduate-level program in nursing accredited by a national accreditation body that is acceptable to the board
- Currently certified by a national certification organization, approved by the board, in one or more of the following nationally recognized
advanced practice registered nursing roles: certified nurse anesthetist, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner

*Citation: W. VA. CODE § 30-7-6.*

For prescriptive authority:

- Successfully completed an advanced pharmacotherapy graduate level course approved by the board of not less than 45 pharmacology contact hours
- Provide documentation of the use of pharmacotherapy in clinical practice in the education program
- Provide evidence of 15 pharmacology contact hours in advanced pharmacotherapy completed within 2 years prior to application
- When required, written verification of an agreement to a collaborative relationship with a licensed physician holding an unencumbered West Virginia license for prescriptive practice
- The Advanced Practice Registered Nurse may have limited prescriptive authority without a collaborative agreement after meeting the following outlined requirements:

Have practiced at least three years in a duly-documented collaborative relationship with granted
prescriptive authority;

Be licensed in good standing with the board;

Submit a completed application on forms developed by the board and pay an application fee.

*Citation: W. VA. CODE ST. R. § 19-8-3(3.1).*

**Wisconsin**

- Current RN license in Wisconsin or in a compact state
- Current certification by a national certifying body approved by the board as a nurse practitioner
- Applicants who receive national certification after July 1, 1998, must have a master’s degree in nursing or a related health field granted by a college or university accredited by a regional accrediting agency approved by the board of education in the state in which the college or university is located

*Citation: WIS. ADMIN. CODE § N 8.02(1).*

**Wyoming**

- RN license in Wyoming or a compact State
- Graduate from a graduate or post-graduate level advanced practice nurse educational program
- Complete a program of study in a role and population focus area of advanced practice registered nursing
- Successfully pass a national certification examination
- Submit evidence of meeting competency under Section 12 of this Chapter

*Citation: WYO. BOARD OF NURSING RULES CH. 2, § 2(a).*

For prescriptive authority:

- Recognition as an advanced practitioner of nursing in Wyoming or a compact State
- Documentation of completion of a minimum of two semester credit hours, three quarter credit hours, or 30 contact hours of course work approved by the board in pharmacology and clinical management of drug therapy or pharmacotherapeutics within the five-year period immediately before the date of application
- Documentation of completion of 400 hours of advanced nursing practice in recognized areas of specialty within the two-year period immediately before the date of application
- Compliance with the standards of nursing practice, the rules and regulations, and the Act

*Citation: WYO. BOARD OF NURSING RULES CH. 4, § 8. (C).*
Chapter 4: Federal Regulation of the Nurse Practitioner Profession

The federal government regulates nurse practitioner (NP) practice through statutes enacted by Congress and by regulations, policies, and guidelines written by federal agencies. Federal law may preempt state law, and when federal and state law conflict, federal law prevails. Where no federal law addresses an issue, or where Congress has expressly given the responsibility to the states to legislate an issue, state law controls.

Federal law addresses the following:

- Care of patients covered by Medicare
- Billing Medicare
- Care of patients covered by Medicaid
- Care of hospitalized patients insofar as participation by hospitals in the Medicare program is contingent on hospitals following certain regulations
- Care of residents in nursing homes
- In-office and hospital laboratories, under the Clinical Laboratory Improvement Amendments (CLIA)
- Self-referral by healthcare providers, under the Stark Acts
- Prohibition against healthcare providers who offer or receive kickbacks (rewards for referrals)
- Prescription of controlled substances, under the Drug Enforcement Administration (DEA)
- Reporting of successful malpractice lawsuits against NPs to the National Practitioner Data Bank (NPDB)
- Confidentiality of information about patients under the Health Insurance Portability and Accountability Act (HIPAA)
- Discrimination in hiring and firing
- Facility access for disabled people
- E-prescribing and electronic medical records

Federal law affects NPs both through what it states explicitly and what it does not.

**Medicare**

Because much of the funding for hospitals and much of the reimbursement for office practice comes from Medicare, federal statutes and regulations and policies from the Centers for Medicare and Medicaid Services (CMS) have great
impact on the interest of hospitals and medical practices that employ NP providers. For example, the Social Security Act, which governs Medicare and Medicaid, was written in 1965, before there were NPs. The Act frequently uses the term *physician* as if there is no other healthcare provider. Other healthcare providers have had to get Congress to pass acts to include them in the laws governing Medicare. The Act has been amended many times since the 1960s, but some relevant portions remain that give permission to physicians and only physicians to provide care.

NPs made progress in 1997 when an act of Congress authorized them to be reimbursed directly for the care of Medicare patients, regardless of setting. However, there still are sections of the federal law that have physician-only language. The Social Security Act still states that a physician must direct the care of hospitalized patients. In late 1997, the Health Care Financing Administration proposed new regulations for hospital participation in Medicare (62 Fed. Reg. 66726-66763). The regulations state that every Medicare patient must be under the care of a physician, dentist, podiatrist, optometrist, chiropractor, or psychologist. The regulation is based on a section of the Social Security Act that states the following:
“Hospital” means an institution which has a requirement that every patient with respect to whom payment may be made under this title must be under the care of a physician, except that a patient receiving qualified psychologist services . . . may be under the care of a clinical psychologist with respect to such services to the extent permitted under state law.

Citation: 42 U.S.C.S. § 1395x(e)(4).

The regulation states that physicians, dentists, podiatrists, optometrists, chiropractors, or psychologists may delegate tasks to other qualified healthcare personnel to the extent recognized under state law or a state’s regulatory mechanism (42 C.F.R. § 482.12). Because the proposed regulation does not use the term nurse practitioner, it is not clear that the regulation contemplates NPs practicing in hospitals. However, it can certainly be argued that NPs are “other qualified healthcare personnel.” Hospitals wishing to serve patients covered by Medicare will want NPs to give care only as delegated by a physician. This may be a limitation for NPs in states where physician collaboration is not required.
NPs may want to lobby Congress for statutory language that specifically authorizes NP participation in the care of Medicare patients in hospitals, at home, in nursing homes, or in offices. Being relegated to the “other qualified personnel” bin is suboptimal for the NP profession. Other providers, most recently psychologists, have successfully lobbied for greater inclusion in the Social Security Act.

As of the date of publication of this text, the areas of federal law that still contain physician-only language are as follows:

- Nursing home law, which states that only a physician may be medical director and a physician must perform the initial comprehensive evaluation
- Home healthcare law, which states that a physician must order home care
- Hospice law, which states that only a physician may be the medical director

**Medicare Reimbursement**

In 1997, direct reimbursement to NPs, regardless of their geographic area of practice, was authorized by Congress. However, the specific procedures by which NPs are reimbursed are frequently revised and clarified as questions arise and answers are
developed. For example, the Budget Reconciliation Act of 1997 removed the provision of the prior law that restricted reimbursement of NPs to those practicing in rural areas and also set the amount paid to 80% of either the lesser of the actual charge or 85% of the fee schedule amount provided under Section 1848. NPs who work for medical practices and can fulfill the requirements of “incident to” or shared visit relationships with physicians can submit their work under a physician’s provider number, and they will receive a full fee (not 85% of the physician fee). In general, however, an NP’s work should be billed under the NP’s provider number. Practitioners who are in doubt should seek an opinion from their Medicare payer or from an appropriate attorney.

What Is “Incident To”?
The full term is “incident to a physician’s professional service.” “Incident to” is a Medicare phrase, meaning services furnished as an “integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness.”¹ To qualify under this definition, the services of nonphysicians must be rendered under a physician’s “direct personal supervision.” Nonphysicians must be employees of a physician or physician group or leased employees, or they must have an independent
contractor relationship with a physician or physician group. Services must be furnished during a course of treatment where a physician performs an initial service and subsequent services of a frequency that reflects the physician’s active participation in and management of a course of treatment. Direct personal supervision in the office setting does not mean that a physician must be in the same room.

However, to bill an incident to a physician’s service, the physician must be in the same suite in the office as the NP at the time the NP performs the service to be billed under the physician’s provider number.

Here is an example:

A patient covered by Medicare visits a physician for the first time and the physician diagnoses high blood pressure. The physician asks the patient to return in a month for a follow-up visit with an NP employed by the physician. The physician is in another room in the office when the patient visits the NP. The NP evaluates and manages the patient’s high blood pressure. Under the “incident to” rules, the NP’s service
(office visit, established patient) may be billed under the physician’s provider number, and the practice will receive 100% of the Physician Fee Schedule rate.

“Incident to” billing is applicable only in the office setting. However, if services are provided in a hospital, whether to inpatients, outpatients, or emergency room patients, there is a way to bill under a physician’s provider number that is similar to “incident to billing,” and the practice can receive 100% of the Physician Fee Schedule rate when NPs perform some of the service. “Shared visits” is a Medicare term for a situation in which both an NP and a physician in the same group provide evaluation and management services to a patient in a hospital. If the rules on “shared visits” are followed, the work of both the NP and the physician may be billed under the physician’s provider number. The rules on shared visits are as follows:

- The NP and physician must belong to the same group, that is, be employed by the same entity.
- Both the NP and physician must document the evaluation and management service they provided to the same patient on the same day.
Both the NP and physician must have a face-to-face visit with the patient that day.

Shared visits apply only to evaluation and management services.

**Federal Definition of Collaboration**

Under federal law, the term “collaboration” means:

A process in which a nurse practitioner works with a physician to deliver healthcare services within the scope of the practitioner’s professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanism as defined by the law of the State in which the services are performed.

*Citation: 42 U.S.C.S. § 1395x(aa)(6).*

The emergence of the NP as a primary provider rather than a supervised helper is not reflected in the Social Security Act. In the Act, an NP is someone to whom a physician may delegate certain tasks. State law either does not require collaboration or calls for “collaboration” but defines it without using the term “supervision.” In contrast, federal law requires, through its definition of
collaboration, “supervision.” It would take an act of Congress to change this.

**Medicare Fraud**
CMS makes the rules regarding the care of Medicare patients and the billing of Medicare. The U.S. Justice Department enforces the rules. NPs who do not follow CMS’s rules can expect to do poorly on audits and may be charged with Medicare fraud and/or abuse.

In the past few years, CMS has reevaluated Medicare’s payment system, upgrading the reimbursement for some evaluation and management functions and downgrading the reimbursement for others. At the same time, CMS has clarified how providers, hospitals, and medical groups should bill, based on the services provided. Of particular interest to NPs are the guidelines jointly developed by CMS and the American Medical Association for coding office visits.

NPs can expect that their Medicare billing choices will be audited, and they will be expected to know the rules for choosing appropriate evaluation and management codes that correlate with the type of visit performed and the documentation recorded. NPs also can expect that the rules for Medicare will
soon become the rules for billing in general. Recently, many NPs have been audited, and in some cases CMS has demanded the return of many thousands of dollars.

For the guidelines for coding office visits covered by Medicare, see Appendix 4-A. For information on specific questions regarding Medicare billing, consult the Medicare manuals, which can be downloaded from the CMS website (http://www.cms.hhs.gov). Medicare reimbursement and avoiding Medicare fraud and abuse are discussed in more detail elsewhere in the text.

**Medicaid**

The federal government has given most of the rule-making and administrative duties for Medicaid to the individual states, and, in most situations, state law controls Medicaid activities. However, the states must follow Federal Code 42 U.S.C.A. § 1396 in such matters as ensuring access to care and offering a choice of providers. Federal law provides that Medicaid will cover the services of pediatric NPs and family NPs, whether or not the NP is employed by or supervised by a physician [42 U.S.C.S. § 1396d(a)(xi)(21)].
The states also must follow CMS rules and regulations regarding administration of Medicaid. For example, states wishing to enroll all Medicaid recipients in managed care have had to apply to CMS for waivers that specify how the managed-care programs will be handled. It has been important for NPs in states that have applied for waivers to ensure that NPs are permitted to be primary care providers. If NPs are not included as providers in the language of state waivers approved by CMS, they can care only for Medicaid patients covered by traditional Medicaid, not patients in managed care. Thus, if all patients are in managed care, NPs who can care only for patients covered by traditional, fee-for-service Medicaid may find that there are no such patients.

NPs must apply to their state agency administering Medicaid for Medicaid provider numbers. For specific questions on Medicaid issues, contact the state Medicaid agency. More information on billing Medicaid is provided elsewhere in the text.

**Nursing Homes**
Under federal law that addresses patients covered by Medicare, residents of a skilled nursing facility must be provided with care under the supervision of a physician [42 U.S.C.S. § 1395i-3(b)(6)(A)]. The
law states, “Skilled nursing facilities must require that the medical care of every resident be provided under the supervision of a physician” [42 U.S.C.S. § 1395i-3(b)(6)(A)] and “provide for having a physician available to furnish necessary medical care in case of emergency” [42 U.S.C.S. § 1395i-3(b)(6)(B)]. Physicians may delegate tasks to other qualified healthcare providers (42 C.F.R. § 483).

Under federal law that addresses patients covered by Medicaid, nursing home residents may be provided care under the supervision of an NP. Medicaid law states the following:

A nursing facility must require that the health care of every resident be provided under the supervision of a physician, or, at the option of a state, under the supervision of a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.

*Citation:* 42 U.S.C.S. § 1396r(b)(6)(A).
Even if the care is supervised by an NP or a physician assistant, a nursing facility must have a physician “available to furnish necessary medical care in case of emergency” [42 U.S.C.S. § 1396r(b)(6)(B)]. And, as of the publication date of this text, only a physician may admit a patient to a skilled nursing facility.

**In-Office and Hospital Laboratories Under the Clinical Laboratory Improvement Amendments**

Office laboratories, no matter how small or limited in scope, are subject to federal oversight under the Clinical Laboratory Improvement Amendments (CLIA). State health departments often require office laboratories to meet certain requirements as well. Office laboratories are subject to state and federal inspection and approval. In offices where laboratory tests are limited to fecal occult blood (hemocult), urine pregnancy test, blood glucose, urinalysis (urine dip), and office microscopy, practices may obtain exemption from inspection. Nevertheless, offices must apply to CLIA for a letter of exemption.

**Self-Referral by Healthcare Providers Under the Stark Acts**
CMS has rules regarding physician referral, titled *Physicians’ Referrals to Health Care Entities With Which They Have Financial Relationships*. These rules relate to the Ethics in Patient Referral Act of 1989 (42 U.S.C. § 1395nn), which was amended by the Omnibus Budget and Reconciliation Act of 1993 and incorporated into the Social Security Act [Social Security Act, 42 U.S.C.A. § 1877 and 1903(s)]. Collectively, these acts are commonly referred to as the “Stark Acts.”

Under the Stark Acts, a physician cannot refer a patient covered by Medicare to a clinical laboratory with which the physician or an immediate family member of the physician has a financial relationship. Nor may a physician refer a patient to certain designated health services when the physician has a financial relationship with the facility offering the services. The designated health services include (1) physical therapy services; (2) occupational therapy services; (3) radiation therapy services; (4) radiology services; (5) durable medical equipment and supplies; (6) parenteral and enteral nutrients; (7) prosthetics, orthotics, and prosthetic devices; (8) home health services; (9) outpatient prescription drugs; and (10) inpatient and outpatient hospital services. The Stark laws originally were aimed at physicians who own an interest in, for
example, medical equipment companies or laboratories, and are in a position to profit when they refer patients for additional services. However, the Stark laws have been interpreted very broadly and now are being used to prohibit hospitals from rewarding physicians who refer patients to the hospitals.

For the purposes of the Stark Acts, referral is defined broadly. A physician may make a referral simply by including a service in the plan of care.

The Stark Acts have wide-ranging application. Just how Stark applies to many situations is still an evolving body of law.

CMS rules allow for certain exceptions from the self-referral prohibitions. For example, there is an exception for ownership and compensation for physicians’ services “provided personally by or under the personal supervision of another physician in the same group practice . . . as the referring physician” [Social Security Act, 42 U.S.C.A. § 1877(b)(1)]. In other words, a physician may refer a patient to another physician in the same group practice without violating the self-referral law.

**How Might Stark Affect NPs?**
The Stark Acts are not aimed at NPs, but rather at physicians. However, if a physician requires an NP employee to refer to an entity with which the physician employer has a financial relationship, then the NP may become involved in an activity that violates the Stark Acts. If the referrals were found to be a violation of the Stark Acts, the referrals would be imputed to the physician employing the NP, rather than the NP. On the other hand, if an NP employee is free to refer to the entity of his or her choice, and he or she independently chooses to refer to an entity in which his or her employer has a financial relationship, it is not clear that a Stark violation has taken place. The Office of the Inspector General has said that such cases would be evaluated based on the specific facts of the situation.

NPs and other healthcare providers wanting to start businesses that might lead to questions regarding the issues described in this section should consult with an attorney.

Here is an example of how Stark laws can enter into an NP’s world: Hospitals have hired NPs to provide admission histories and physicals, hospital visits, and consultations and procedures for hospitalized individuals. Sometimes, hospitals allow their
employed NPs to perform services for privately employed physicians. For example, a hospital-employed nurse practitioner may visit a cardiologist’s hospitalized patient in the morning, perform a history and physical, and write daily orders. Sometimes, a privately employed physician will visit the patient later in the day, may or may not provide additional services, will write “agree” under the NP’s note, and will bill for a hospital visit. In this case, the physician has incorporated the NP’s work as his or her own, for billing purposes. The privately employed physician has no right to bill for services provided by a hospital-employed NP; only the employer, the hospital, has that right. So the physician is billing in error. Here is where Stark law applies: The hospital has allowed the NP to perform services that are billable by the hospital, but the hospital has declined to bill for those services and lets the physician bill for the services. The hospital essentially has given the physician a prize—the services of the NP. This violates Stark laws, which prohibit a hospital from giving a private physician more than $392 per year in nonmonetary compensation. (The monetary value increases slightly from year to year, and $392 is the limit for 2016.) Stark laws are aimed to prohibit hospitals or other entities from paying for referrals. While the hospital in this scenario is not paying the physician
a set amount per referral, the hospital is subsidizing the physician, by giving the services of the NP to the physician. It would be appropriate for the physician to hire an NP within his or her own practice, but if the hospital is willing to supply an NP, the physician doesn’t have to pay that salary. While NPs are unlikely to get into legal trouble by being a part of this scenario, hospitals and physicians have been fined and sanctioned for this type of arrangement. One way to make this scenario legal for both the physician and the hospital is for the physician practice to lease the NP’s services from the hospital, through a written agreement and for an amount that reflects the arm’s-length value of the NP’s services. It is the responsibility of the hospital and its compliance department to make sure that practice models in which a hospital and physician group share the services of an NP conform to Stark laws.

**Anti-Kickback Statute**

Under federal law, there are criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration (i.e., anything of value, in cash or in kind) in order to induce the referral of business reimbursable by a federal healthcare program. The statute prohibiting these activities—kickbacks—is at 42 U.S.C. §
Violations of the anti-kickback statute also may result in civil monetary penalties. The statute has been in existence since 1977. It applies to all kinds of healthcare providers and suppliers.

The law was enacted because Congress believed that payments tied to referrals increase the likelihood of overutilization of items and services, increase the cost of healthcare programs, lead to inappropriate referrals, and make competition unfair.

Examples of kickbacks include the following:

- Waiving deductibles and copayments for Medicare patients
- Paying an NP or a physician a fee for referring a patient
- Accepting a fee for referring a patient

**Implications for NPs**

At least two NPs have been prosecuted for taking kickbacks. In one case, the NP accepted money from a laboratory in return for sending business their way. In another case, an NP was charged with taking kickbacks from a pharmaceutical company in return for frequently prescribing the company’s medications. The kickback came in the form of the company’s paying the NP hefty speaking fees, when
the speeches were sometimes attended by only the NP and the company’s sales representative.

**Prescription of Controlled Substances Under the DEA**

The DEA licenses healthcare providers who prescribe controlled dangerous substances. The DEA licenses NPs as “mid-level practitioners” (21 C.F.R. § 1301, 1304, and 1306.3). The DEA will assign an NP a DEA number if the NP has no felony on record, if the NP has a practice site, and if state law permits NPs to prescribe controlled substances. Controlled substances may be issued only by a practitioner who is authorized to prescribe controlled substances by the jurisdiction in which the practitioner is licensed to practice and has either registered or is exempt from registration.

**Reporting to the National Practitioner Data Bank**

Under federal law (42 C.F.R. § 60), malpractice insurers must report damage awards paid on behalf of physicians, dentists, NPs, and some other healthcare providers to the National Practitioner Data Bank (NPDB), a national repository of information on healthcare providers. The NPDB is discussed in more detail elsewhere in the text.
Patient Confidentiality

Federal law requires NPs and other healthcare providers to protect patient privacy and confidentiality. Specific federal laws protect the privacy of patients with substance abuse problems (42 U.S.C. § 290dd-2), patients with mental health problems (42 U.S.C. § 9501), and patients who are residents of nursing homes [42 U.S.C. § 1395e-3(C)(x)(A)(iv)].

Patient Privacy

Congress mandated the Department of Health and Human Services to promulgate rules governing privacy in health care under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The following are incidents that inspired Congress to pass the privacy protection requirements:

- A health system in Michigan accidentally posted the medical records of thousands of patients on the Internet (1999 report).
- A businessman purchased at auction the medical records of patients at a family practice in South Carolina and attempted to sell them back to the former patients (1991 report).
- Johnson & Johnson marketed a list of 5 million elderly women who had been treated for incontinence (1998 report).
Under the Final Rule ("Standards for Privacy of Individually Identifiable Health Information, Final Rule," Federal Register, December 28, 2000, pp. 82462–82829), any individual, organization, or facility that meets the definition of “covered entity” must do the following:

- Appoint a privacy officer
- Assess the office, hospital, or facility for potential for breaches of patient privacy
- Issue policies regarding handling and protection of patient information
- Conduct training for staff about the policies
- Monitor office or facility procedures for compliance with policies
- Get patients to authorize, in writing, any release of their individually identifiable information for marketing purposes
- Notify patients, in writing, of their rights under the rules, and make a good-faith effort to get patients to sign an acknowledgment that they have received notice of their rights
- Provide patients with their own medical records, within 30 days of a patient’s request

“Covered entities” include the following:

- Health plans
- Healthcare clearinghouses
Healthcare providers who transmit any health information in electronic form in connection with a transaction

“Healthcare providers” include the following:

- Hospitals
- Skilled nursing facilities
- Comprehensive outpatient rehabilitation facilities
- Home health agencies
- Hospice programs
- NPs
- Certified nurse midwives
- Clinical nurse specialists
- Psychologists
- Clinical social workers
- Certified registered nurse anesthetists
- Physicians and physician assistants
- “...[A]nd any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.”

An individual healthcare provider—an NP, for example—need not personally transmit health information in electronic form for the rules to apply. If information is transmitted on the provider’s behalf or by the provider’s agency, the rules apply. The rules also apply to “business associates” of healthcare providers.
Basic requirements of the privacy rule are as follows:

- Providers and their staff are restricted to conveying the “minimum necessary information” about patients. “Minimum necessary” must be defined by organizational policy. Providers must establish policies that (1) identify the persons or classes of persons in the workforce who need access to protected patient information to do their jobs, (2) specify the information these workers may access, and (3) specify how information is protected from inspection by unauthorized individuals.

- If a provider wants to release patient information for marketing purposes, the provider must first explain to the patient how the information will be used, to whom it will be disclosed, and the time frame. The patient needs to authorize use of the information in writing. If the provider will be paid for releasing the patient’s information, the provider must inform the patient of that fact.

- Providers may disclose health information to oversight agencies such as CMS without patient authorization. No authorization is required for victims of abuse, neglect, or domestic violence when state law mandates that the provider report abuse. No separate authorization is required
when information is used for public health purposes or for organ and tissue donation. No authorization is required under certain circumstances involving law enforcement.

- There are special rules for psychotherapy notes. In general, patient authorization is required to disclose psychotherapy notes to carry out treatment, payment, or healthcare operations. Patients may authorize disclosure of their entire records. Such authorizations must include the name or class of the persons authorized to disclose and an expiration date or event.

- Providers must notify patients about how personal medical information may be used and disclosed, and how individuals may access their own information. Individuals have no right to three types of information about themselves: psychotherapy notes, information compiled in anticipation of civil or criminal litigation, and certain clinical laboratory information covered by the CLIA.

- Providers must accommodate reasonable requests from patients who want to restrict use of their information.

**Discrimination in Hiring and Firing**

Federal law prohibits discrimination based on race, color, sex, national origin, age, and disability. Title VII of the Civil Rights Act of 1964, which prohibits
discrimination based on race, color, or national origin, applies to government employers and private employers with more than 15 employees. The Age Discrimination Act of 1967 prohibits discrimination based on age above 40 and applies to employers with more than 20 employees. The Equal Pay Act of 1963 prohibits wage discrimination between men and women and applies to most employers.

**Requirements Under the Americans with Disabilities Act**
Title I of the Americans with Disabilities Act of 1990 prohibits private employers from discriminating against qualified individuals in hiring, firing, advancement, compensation, job training, and conditions of employment. A disabled person is one who has a physical or mental impairment that substantially limits one or more major life activities. The Act applies to employers with more than 15 employees.

**Note**
Appendix 4-A Documentation Guidelines for Evaluation and Management Services

This is an update of the guidelines jointly produced by the American Medical Association (AMA) and the Health Care Financing Administration (HCFA) in May 1997. It appears on the Centers for Medicare and Medicaid Services (CMS) website at http://www.cms.gov. It incorporates revisions to the gastrointestinal section of the general multisystem exam and the skin section of the single-organ system exam of the skin. These revisions were approved by the AMA and CMS in November 1997. This is not the final version of the guidelines. This version of the guidelines will be reviewed and may be amended before Medicare carriers begin to use it in compliance activities. NPs should check the CMS website periodically to determine whether revisions have been published.

Foreword
These guidelines were developed jointly by the American Medical Association (AMA) and the Health Care Financing Administration (HCFA), now known as the Centers for Medicare and Medicaid Services (CMS). The stated goal was to provide physicians and claims reviewers with advice about preparing or reviewing documentation for Evaluation and Management services. In developing and testing the validity of these guidelines, special emphasis was placed on assuring that they:

- Are consistent with the clinical descriptors and definitions contained in Current Procedural Terminology (CPT);
- Would be widely accepted by clinicians and minimize any changes in record-keeping practices; and
- Would be interpreted and applied uniformly by users across the country.

This edition contains a substantial amount of new material and a number of significant revisions in material that appeared in the first edition. Because of the extensive changes, the section on examination should be read in its entirety. In this edition:

- The content of general multisystem examinations has been defined with greater
clinical specificity.
- Documentation requirements for general multisystem examinations have been changed.
- For the first time, content and documentation requirements have been defined for examinations pertaining to ten organ systems. The content of these examinations was developed with the assistance of representatives from the specialties that frequently perform these examinations.
- Several editorial changes have been made in the definitions of the four types of examinations. This text also appears in CPT itself in the section headed “Evaluation and Management (E/M) Services Guidelines.”
- The definition of an extended history of present illness has been expanded to include information about chronic or inactive conditions.

Documentation Guidelines for Evaluation and Management Services

I. Introduction
What Is Documentation and Why Is It Important?
Medical record documentation is required to record pertinent facts, findings, and observations about an individual’s health history including past and present
illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high-quality care. The medical record facilitates:

- The ability of the physician and other healthcare professionals to evaluate and plan the patient’s immediate treatment, and to monitor his/her health care over time;
- Communication and continuity of care among physicians and other healthcare professionals involved in the patient’s care;
- Accurate and timely claims review and payment;
- Appropriate utilization review and quality of care evaluations; and
- Collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the “hassles” associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

**What Do Payers Want and Why?**
Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the
insurance coverage provided. They may request information to validate:

- The site of service;
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- That services provided have been accurately reported.

II. General Principles of Medical Record Documentation

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation vary by type of service, place of service, and the patient’s status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
   - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
Assessment, clinical impression, or diagnosis;
Plan for care; and
Date and legible identity of the observer.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

4. Past and present diagnoses should be accessible to the treating and/or consulting physician.

5. Appropriate health risk factors should be identified.

6. The patient’s progress, response to, and changes in treatment, and revision of diagnosis should be documented.

7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

III. Documentation of E/M Services
This publication provides definitions and documentation guidelines for the three key components of E/M services and for visits that consist predominately of counseling or coordination of care. The three key components—history, examination, and medical decision making—appear in the descriptors for office and other outpatient
services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. Documentation guidelines are identified by the symbol “•DG.”

The descriptors for the levels of E/M services recognize seven components that are used in defining the levels of E/M services. These components are:

- History,
- Examination,
- Medical decision making,
- Counseling,
- Coordination of care,
- Nature of presenting problem, and
- Time.

The first three of these components (i.e., history, examination, and medical decision making) are the key components in selecting the level of E/M services. In the case of visits that consist predominantly of counseling or coordination of care,
time is the key or controlling factor to qualify for a particular level of E/M service.

Because the level of E/M service is dependent on two or three key components, performance and documentation of one component (e.g., examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.

These documentation guidelines for E/M services reflect the needs of the typical adult population. For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents, and pregnant women may have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present illness (HPI) the details of the mother’s pregnancy and the infant’s status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, the content of a pediatric examination will vary with the age and development of the child. Although not specifically defined in these documentation
guidelines, these patient group variations on history and examination are appropriate.

A. Documentation of History
The levels of E/M services are based on four types of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC)
- History of present illness (HPI)
- Review of systems (ROS)
- Past, family, and/or social history (PFSH)

The extent of history of present illness; review of systems; and past, family, and/or social history that is obtained and documented is dependent on clinical judgment and the nature of the presenting problem(s). The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history all three elements in the table must be met. (A chief complaint is indicated at all levels.)

<table>
<thead>
<tr>
<th>History of Present Illness (HPI)</th>
<th>Review of Systems (ROS)</th>
<th>Past, Family, and/or Social History (PFSH)</th>
<th>Type of History</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
- **DG:** The CC, ROS, and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.

- **DG:** An ROS and/or a PFSH obtained during an earlier encounter does not need to be rerecorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:
  - Describing any new ROS and/or PFSH information or noting there has been no change in the information; and
  - Noting the date and location of the earlier ROS and/or PFSH.
• *DG:* The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

• *DG:* If the physician is unable to obtain a history from the patient or other source, the record should describe the patient’s condition or other circumstance that precludes obtaining a history.

Definitions and specific documentation guidelines for each of the elements of history are listed below.

**Chief Complaint (CC)**
The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient’s words.

• *DG:* The medical record should clearly reflect the chief complaint.

**History of Present Illness (HPI)**
The HPI is a chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous
encounter to the present. It includes the following elements:

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated signs and symptoms

Brief and extended HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

A brief HPI consists of one to three elements of the HPI.

- *DG: The medical record should describe one to three elements of the present illness (HPI).*

An extended HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

- *DG: The medical record should describe at least four elements of the present illness (HPI), or the*
status of at least three chronic or inactive conditions.

Review of Systems (ROS)
An ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.

For purposes of ROS, the following systems are recognized:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/lymphatic
- Allergic/immunologic
A problem pertinent ROS inquires about the system directly related to the problem(s) identified in the HPI.

- **DG:** The patient’s positive responses and pertinent negatives for the system related to the problem should be documented.

An extended ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

- **DG:** The patient’s positive responses and pertinent negatives for two to nine systems should be documented.

A complete ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.

- **DG:** At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.
Past, Family, and/or Social History (PFSH)

The PFSH consists of a review of three areas:

- Past history (the patient’s past experiences with illnesses, operations, injuries, and treatments),
- Family history (a review of medical events in the patient’s family, including diseases that may be hereditary or place the patient at risk), and
- Social history (an age-appropriate review of past and current activities).

For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations, and subsequent nursing facility care.

A pertinent PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

- **DG: At least one specific item from any of the three history areas must be documented for a pertinent PFSH.**

A complete PFSH is a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature
include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

- **DG**: At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; domiciliary care, established patient; and home care, established patient.

- **DG**: At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and home care, new patient.

### B. Documentation of Examination

The levels of E/M services are based on four types of examination:

- **Problem Focused**—a limited examination of the affected body area or organ system.
- **Expanded Problem Focused**—a limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).
- **Detailed**—an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).
- **Comprehensive**—a general multisystem examination or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).

These types of examinations have been defined for general multisystems and the following single organ systems:

- Cardiovascular
- Ears, nose, mouth, and throat
- Eyes
- Genitourinary (female)
- Genitourinary (male)
- Hematologic/lymphatic/immunologic
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin
A general multisystem examination or a single organ system examination may be performed by any physician regardless of specialty. The type (general multisystem or single organ system) and content of examination are selected by the examining physician and are based on clinical judgment, the patient’s history, and the nature of the presenting problem(s).

The content and documentation requirements for each type and level of examination are summarized next and described in detail in tables found later in this chapter. In the tables, organ systems and body areas recognized by CPT for purposes of describing examinations are shown in the left column. The content, or individual elements, of the examination pertaining to that body area or organ system are identified by bullets (*) in the right column.

Parenthetical examples “(e.g., . . .)” have been used for clarification and to provide guidance regarding documentation. Documentation for each element must satisfy any numeric requirements (such as “Measurement of any three of the following seven . . .”) included in the description of the element. Elements with multiple components but with no specific numeric requirement (such as “Examination of liver and spleen”) require documentation of at
least one component. It is possible for a given examination to be expanded beyond what is defined here. When that occurs, findings related to the additional systems and/or areas should be documented.

- **DG:** Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is insufficient.
- **DG:** Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.
- **DG:** A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

### General Multisystem Examinations

In this section, general multisystem examinations are described in detail. To qualify for a given level of multisystem examination, the following content and documentation requirements should be met:

- Problem Focused Examination—should include performance and documentation of one to five
elements identified by a bullet (•) in one or more organ system(s) or body area(s).

- Expanded Problem Focused Examination—should include performance and documentation of at least six elements identified by a bullet (•) in one or more organ system(s) or body area(s).
- Detailed Examination—should include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet (•) are expected. Alternatively, a detailed examination may include performance and documentation of at least twelve elements identified by a bullet (•) in two or more organ systems or body areas.
- Comprehensive Examination—should include at least nine organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet (•) should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least two elements identified by a bullet is expected.

**Single Organ System Examinations**
The single organ system examinations recognized by CPT are described in detail later in this appendix. Variations among these examinations in the organ systems and body areas identified in the left
columns and in the elements of the examinations described in the right columns reflect differing emphases among specialties. To qualify for a given level of single organ system examination, the following content and documentation requirements should be met:

- **Problem Focused Examination**—should include performance and documentation of one to five elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
- **Expanded Problem Focused Examination**—should include performance and documentation of at least six elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
- **Detailed Examination**—examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet (•), whether in a box with a shaded or unshaded border. Eye and psychiatric examinations should include the performance and documentation of at least nine elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
- **Comprehensive Examination**—should include performance of all elements identified by a bullet
(•), whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in each box with an unshaded border is expected.

Note
This is the most recent version of the guidelines as of 2016.

Content and Documentation Requirements
General Multisystem Examination

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
</table>
| Constitutional   | • Measurement of any three of the following seven vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (may be measured and recorded by ancillary staff)  
• General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming) |
| Eyes             | • Inspection of conjunctivae and lids  
• Examination of pupils and irises (e.g., reaction to light and accommodation, size, and symmetry) |
| Ears, Nose, Mouth, and Throat | • Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)  
• External inspection of ears and nose (e.g., overall appearance and throat scars, lesions, masses)  
• Otoscopic examination of external auditory canals and tympanic membranes  
• Assessment of hearing (e.g., whispered voice, finger rub, tuning fork)  
• Inspection of nasal mucosa, septum, and turbinates  
• Inspection of lips, teeth, and gums  
• Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils, and posterior pharynx |
<table>
<thead>
<tr>
<th>Area</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>• Palpation of heart (e.g., location, size, thrills)</td>
</tr>
<tr>
<td></td>
<td>• Auscultation of heart with notation of abnormal sounds and murmurs</td>
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<tr>
<td></td>
<td>Examination of:</td>
</tr>
<tr>
<td></td>
<td>• Carotid arteries (e.g., pulse amplitude, bruits)</td>
</tr>
<tr>
<td></td>
<td>• Abdominal aorta (e.g., size, bruits)</td>
</tr>
<tr>
<td></td>
<td>• Femoral arteries (e.g., pulse amplitude, bruits)</td>
</tr>
<tr>
<td></td>
<td>• Pedal pulses (e.g., pulse amplitude)</td>
</tr>
<tr>
<td></td>
<td>• Extremities for edema and/or varicosities</td>
</tr>
<tr>
<td>Chest (Breasts)</td>
<td>• Inspection of breasts (e.g., symmetry, nipple discharge)</td>
</tr>
<tr>
<td></td>
<td>• Palpation of breasts and axillae (e.g., masses or lumps, tenderness)</td>
</tr>
<tr>
<td>Gastrointestinal (Abdomen)</td>
<td>• Examination of abdomen with notation of presence of masses or tenderness</td>
</tr>
<tr>
<td></td>
<td>• Examination of liver and spleen</td>
</tr>
<tr>
<td></td>
<td>• Examination for presence or absence of hernia</td>
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<tr>
<td></td>
<td>• Examination (when indicated) of anus, perineum, and rectum, including</td>
</tr>
<tr>
<td></td>
<td>sphincter tone, presence of hemorrhoids, rectal masses</td>
</tr>
<tr>
<td></td>
<td>• Obtain stool sample for occult blood test when indicated</td>
</tr>
</tbody>
</table>
## Genitourinary

### MALE:

- Examination of the scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass)
- Examination of the penis
- Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness)

### FEMALE:

- Pelvic examination (with or without specimen collection for smears and cultures), including:
  - Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)
  - Examination of urethra (e.g., masses, tenderness, scarring)
  - Examination of bladder (e.g., fullness, masses, tenderness)
  - Cervix (e.g., general appearance, lesions, discharge)
  - Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent, or support)
<table>
<thead>
<tr>
<th>Lymphatic</th>
<th>Palpation of lymph nodes in two or more areas:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Neck</td>
</tr>
<tr>
<td></td>
<td>• Axillae</td>
</tr>
<tr>
<td></td>
<td>• Groin</td>
</tr>
<tr>
<td></td>
<td>• Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Musculoskeletal</th>
<th>Examination of gait and station</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Examination of joints, bones, and muscles of one or more of the following six areas: (1) head and neck; (2) spine, ribs, and pelvis; (3) right upper extremity; (4) left upper extremity; (5) right lower extremity; and (6) left lower extremity. The examination of a given area includes:</td>
</tr>
<tr>
<td></td>
<td>• Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions</td>
</tr>
<tr>
<td></td>
<td>• Assessment of range of motion with notation of any pain, crepitation, or contracture</td>
</tr>
<tr>
<td></td>
<td>• Assessment of stability with notation of any dislocation (luxation), subluxation, or laxity</td>
</tr>
</tbody>
</table>
- Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements

| Skin          | • Inspection of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)  
|               | • Palpation of skin and subcutaneous tissue (e.g., induration, subcutaneous nodules, tightening) |

| Neurological  | • Test cranial nerves with notation of any deficits  
|               | • Examination of deep tendon reflexes with notation of pathological reflexes (e.g., Babinski)  
|               | • Examination of sensation (e.g., by touch, pin, vibration, proprioception) |

| Psychiatric   | • Description of patient’s judgment and insight  
|               | • Brief assessment of mental status including:  
|               |   • Orientation to time, place, and person  
|               |   • Recent and remote memory  
|               |   • Mood and affect (e.g., depression, anxiety, agitation) |

**Content and Documentation Requirements**
<table>
<thead>
<tr>
<th>Level of Exam</th>
<th>Perform and Document:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>One to five elements identified by a bullet.</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>At least six elements identified by a bullet.</td>
</tr>
<tr>
<td>Detailed</td>
<td>At least two elements identified by a bullet from each of six areas/systems OR at least twelve elements identified by a bullet in two or more areas/systems.</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Perform all elements identified by a bullet in at least nine organ systems or body areas and document at least two elements identified by a bullet from each of nine areas/systems.</td>
</tr>
</tbody>
</table>

**Cardiovascular Examination**

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td>- Measurement of any three of the following seven vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (may be measured and recorded by ancillary staff)</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>General appearance of patient</td>
<td>General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)</td>
</tr>
<tr>
<td>Head and Face</td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td>Inspection of conjunctivae and lids (e.g., xanthelasma)</td>
</tr>
<tr>
<td>Ears, Nose, Mouth, and Throat</td>
<td>Inspection of teeth, gums, palate, and throat</td>
</tr>
<tr>
<td></td>
<td>Inspection of oral mucosa with notation of presence of pallor or cyanosis</td>
</tr>
<tr>
<td>Neck</td>
<td>Examination of jugular veins (e.g., distension; a, v, or cannon a waves)</td>
</tr>
<tr>
<td></td>
<td>Examination of thyroid (e.g., enlargement, tenderness, mass)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)</td>
</tr>
<tr>
<td></td>
<td>Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
</tr>
</tbody>
</table>
- Palpation of heart (e.g., location, size, and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4)
- Auscultation of heart including sounds, abnormal sounds, and murmurs
- Measurement of blood pressure in two or more extremities when indicated (e.g., aortic dissection, coarctation)
- Examination of:
  - Carotid arteries (e.g., waveform, pulse amplitude, bruits, apicalcarotid delay)
  - Abdominal aorta (e.g., size, bruits)
  - Femoral arteries (e.g., pulse amplitude, bruits)
  - Pedal pulses (e.g., pulse amplitude)
  - Extremities for peripheral edema and/or varicosities

<table>
<thead>
<tr>
<th>Chest (Breasts)</th>
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</table>

<table>
<thead>
<tr>
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</tr>
</thead>
</table>
- Examination of abdomen with notation of presence of masses (Abdomen) or tenderness
- Examination of liver and spleen
- Obtain stool sample for occult blood from patients who are being
<table>
<thead>
<tr>
<th></th>
<th>Considered for thrombolytic or anticoagulant therapy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genitourinary</td>
<td></td>
</tr>
<tr>
<td>Lymphatic</td>
<td></td>
</tr>
</tbody>
</table>
| Musculoskeletal | - Examination of the back with notation of kyphosis or scoliosis  
- Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs  
- Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements |
| Extremities | - Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, Osler's nodes) |
| Skin      | - Inspection and/or palpation of skin and subcutaneous tissue  
  - (e.g., stasis dermatitis, ulcers, scars, xanthomas) |
| Neurological/Psychiatric | - Brief assessment of mental status including Psychiatric |
Orientation to time, place, and person
Mood and affect (e.g., depression, anxiety, agitation)

Content and Documentation Requirements

<table>
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<tr>
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</table>

Ear, Nose, Mouth, and Throat Examination

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td>• Measurement of any three of the following seven vital signs: (1) sitting or standing blood pressure,</td>
</tr>
</tbody>
</table>
(2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (may be measured and recorded by ancillary staff)

- General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
- Assessment of ability to communicate (e.g., use of sign language or other communication aids) and quality of voice

| Head and Face | • Inspection of head and face (e.g., overall appearance, scars, lesions, and masses)  
|              | • Palpation and/or percussion of face with notation of presence or absence of sinus tenderness  
|              | • Examination of salivary glands  
|              | • Assessment of facial strength |

| Eyes | • Test ocular motility including primary gaze alignment |

| Ears, Nose, Mouth, and Throat | • Otoscopic examination of external auditory canals and tympanic membranes including pneumootoscopy with notation of mobility of membranes |
• Assessment of hearing with tuning forks and clinical speech reception thresholds (e.g., whispered voice, finger rub)
• External inspection of ears and nose (e.g., overall appearance, scars, lesions, and masses)
• Inspection of nasal mucosa, septum, and turbinates
• Inspection of lips, teeth, and gums
• Examination of oropharynx: oral mucosa, hard and soft palates, tongue, tonsils, and posterior pharynx (e.g., asymmetry, lesions, hydration of mucosal surfaces)
• Inspection of pharyngeal walls and pyriform sinuses (e.g., pooling of saliva, asymmetry, lesions)
• Examination by mirror of larynx including the condition of the epiglottis, false vocal cords, true vocal cords, and mobility of larynx (use of mirror not required in children)
• Examination by mirror of nasopharynx including appearance of the mucosa, adenoids, posterior choanae, and eustachian tubes (use of mirror not required in children)
| Neck | - Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)  
|      | - Examination of thyroid (e.g., enlargement, tenderness, mass) |
| Respiratory | - Inspection of chest including symmetry, expansion, and/or assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)  
|      | - Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs) |
| Cardiovascular | - Auscultation of heart with notation of abnormal sounds and murmurs  
<p>|      | - Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness) |
| Chest (Breasts) |  |
| Gastrointestinal (Abdomen) |  |
| Genitourinary |  |
| Lymphatic | - Palpation of lymph nodes in neck, axillae, groin, and/or other location |</p>
<table>
<thead>
<tr>
<th>Musculoskeletal</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Extremities</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
</tr>
</tbody>
</table>
| Neurological/Psychiatric | - Test cranial nerves with notation of any deficits  
|                  | - Brief assessment of mental status including:  
|                  |   - Orientation to time, place, and person  
|                  |   - Mood and affect (e.g., depression, anxiety, agitation) |

### Content and Documentation Requirements

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# Eye Examination

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<td></td>
</tr>
<tr>
<td>Head and Face</td>
<td></td>
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</tbody>
</table>
| Eyes             | - Test visual acuity (does not include determination of refractive error)  
                    - Gross visual field testing by confrontation  
                    - Test ocular motility including primary gaze alignment  
                    - Inspection of bulbar and palpebral conjunctivae  
                    - Examination of ocular adnexae including lids (e.g., ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits, and preauricular lymph nodes  
                    - Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size (e.g., anisocoria), and morphology  
                    - Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film  
                    - Slit lamp examination of the anterior chambers including depth, |
- Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus
- Measurement of intraocular pressures (except in children and patients with trauma or infectious disease)
- Ophthalmoscopic examination through dilated pupils (unless contraindicated) of:
  - Optic discs including size, C/D ratio, appearance (e.g., atrophy, cupping, tumor elevation), and nerve fiber layer
  - Posterior segments including retina and vessels (e.g., exudates and hemorrhages)

<table>
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<tbody>
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<td>Neck</td>
</tr>
<tr>
<td>Respiratory</td>
</tr>
<tr>
<td>Cardiovascular</td>
</tr>
<tr>
<td>Chest (Breasts)</td>
</tr>
<tr>
<td>Gastrointestinal (Abdomen)</td>
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<tr>
<td>Genitourinary</td>
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<tr>
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<tr>
<td>Lymphatic</td>
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<tr>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>Extremities</td>
</tr>
<tr>
<td>Skin</td>
</tr>
</tbody>
</table>
| Neurological/Psychiatric | - Brief assessment of mental status including:  
  - Orientation to time, place, and person  
  - Mood and affect (e.g., depression, anxiety, agitation) |

### Content and Documentation Requirements

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Genitourinary Examination

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<tbody>
<tr>
<td>Constitutional</td>
<td>• Measurement of any three of the following seven vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (may be measured and recorded by ancillary staff)</td>
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<td></td>
<td>• General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)</td>
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<tr>
<td>Head and Face</td>
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<tr>
<td>Eyes</td>
<td></td>
</tr>
<tr>
<td>Ears, Nose, Mouth, and Throat</td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td>• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
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<td>------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tbody>
</table>
| Respiratory      | - Examination of thyroid (e.g., enlargement, tenderness, mass)  
                    - Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)  
                    - Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)                                                                                                                             |
| Cardiovascular   | - Auscultation of heart with notation of abnormal sounds and murmurs  
                    - Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)   |
| Chest (Breasts)  | [See genitourinary (female)]                                                                                                                                                                                 |
| Gastrointestinal | - Examination of abdomen with notation of presence of masses or tenderness  
                    - Examination for presence or absence of hernia  
                    - Examination of liver and spleen  
                    - Obtain stool sample for occult blood test when indicated                                                                                                                                             |
| Genitourinary    | **MALE:**  
                    - Inspection of anus and perineum                                                                                                                                                                         |
Examination (with or without specimen collection for smears and cultures) of genitalia including:

- Scrotum (e.g., lesions, cysts, rashes)
- Epididymides (e.g., size, symmetry, masses)
- Testes (e.g., size, symmetry, masses)
- Urethral meatus (e.g., size, location, lesions, discharge)
- Penis (e.g., lesions, presence or absence of foreskin, foreskin retractability, plaque, masses, scarring, deformities)

Digital rectal examination including:

- Prostate gland (e.g., size, symmetry, nodularity, tenderness)
- Seminal vesicles (e.g., symmetry, tenderness, masses, enlargement)
- Sphincter tone, presence of hemorrhoids, rectal masses

**FEMALE:**

Includes at least seven of the following eleven elements identified:

- Inspection and palpation of breasts (e.g., masses or lumps,
• Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses
• Pelvic examination (with or without specimen collection for smears and cultures) including:
  • External genitalia (e.g., general appearance, hair distribution, lesions)
  • Urethral meatus (e.g., size, location, lesions, prolapse)
  • Urethra (e.g., masses, tenderness, scarring)
  • Bladder (e.g., fullness, masses, tenderness)
  • Vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)
  • Cervix (e.g., general appearance, lesions, discharge)
  • Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent, or support)
  • Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)
• Anus and perineum
### Content and Documentation Requirements

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<td>Detailed</td>
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</tbody>
</table>

- **Lymphatic**  - Palpation of lymph nodes in neck, axillae, groin, and/or other location
- **Musculoskeletal**
- **Extremities**
- **Skin**  - Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)
- **Neurological/Psychiatric**  - Brief assessment of mental status including:
  - Orientation (e.g., time, place, and person)
  - Mood and affect (e.g., depression, anxiety, agitation)
Perform all elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

Hematologic/Lymphatic/Immunologic Examination

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<tr>
<th>System/Body Area</th>
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</thead>
</table>
| Constitutional   | • Measurement of any three of the following seven vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (may be measured and recorded by ancillary staff)  
• General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming) |
<p>| Head and Face    | • Palpation and/or percussion of face with notation of presence or absence of sinus tenderness |
| Eyes             | • Inspection of conjunctivae and lids |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ears, Nose, Mouth, and</td>
<td>• Otoscopic examination of external auditory canals and tympanic membranes</td>
</tr>
<tr>
<td>Throat</td>
<td>• Inspection of nasal mucosa, septum, and turbinates</td>
</tr>
<tr>
<td></td>
<td>• Inspection of teeth and gums</td>
</tr>
<tr>
<td></td>
<td>• Examination of oropharynx (e.g., oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx)</td>
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<tr>
<td>Neck</td>
<td>• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)</td>
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<td>• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)</td>
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<td>• Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)</td>
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<td>Cardiovascular</td>
<td>• Auscultation of heart with notation of abnormal sounds and murmurs</td>
</tr>
<tr>
<td></td>
<td>• Examination of peripheral vascular system by observation</td>
</tr>
<tr>
<td></td>
<td>• (e.g., swelling, varicosities), and palpation (e.g., pulses, temperature, edema, tenderness)</td>
</tr>
<tr>
<td>System</td>
<td>Examination/Assessment</td>
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<tr>
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</tr>
<tr>
<td>Chest (Breasts)</td>
<td></td>
</tr>
</tbody>
</table>
| Gastrointestinal| • Examination of abdomen with notation of presence of masses or tenderness
• Examination of liver and spleen |
| Genitourinary   |                                                                                       |
| Lymphatic       | • Palpation of lymph nodes in neck, axillae, groin, and/or other location               |
| Musculoskeletal |                                                                                       |
| Extremities     | • Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes) |
| Skin            | • Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers, ecchymoses, bruises) |
| Neurological/Psychiatric | • Brief assessment of mental status including:
  • Orientation to time, place, and person
  • Mood and affect (e.g., depression, anxiety, agitation) |
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Musculoskeletal Examination

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<tbody>
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<td>Constitutional</td>
<td>• Measurement of any three of the following seven vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (may be</td>
</tr>
</tbody>
</table>
measured and recorded by ancillary staff)

- General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

<table>
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<tr>
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<tbody>
<tr>
<td>Eyes</td>
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<tr>
<td>Ears, Nose, Mouth, and Throat</td>
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<tr>
<td>Neck</td>
</tr>
<tr>
<td>Respiratory</td>
</tr>
<tr>
<td>Cardiovascular</td>
</tr>
<tr>
<td>• Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)</td>
</tr>
<tr>
<td>Chest (Breasts)</td>
</tr>
<tr>
<td>Gastrointestinal (Abdomen)</td>
</tr>
<tr>
<td>Genitourinary</td>
</tr>
<tr>
<td>Lymphatic</td>
</tr>
<tr>
<td>• Palpation of lymph nodes in neck, axillae, groin, and/or other location</td>
</tr>
</tbody>
</table>
**Musculoskeletal**

- Examination of gait and station
- Examination of joint(s), bone(s), and muscle(s)/tendon(s) of four of the following six areas: (1) head and neck; (2) spine, ribs, and pelvis; (3) right upper extremity; (4) left upper extremity; (5) right lower extremity; and (6) left lower extremity. The examination of a given area includes:
  - Inspection, percussion, and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses, or effusions
  - Assessment of range of motion with notation of any pain (e.g., straight leg raising), crepitation, or contracture
  - Assessment of stability with notation of any dislocation (luxation), subluxation, or laxity
  - Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements

**NOTE:** For the comprehensive level of examination, all four of the elements identified by a bullet must be performed and documented for each
of four anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two extremities constitutes two elements.

<table>
<thead>
<tr>
<th>Extremities</th>
<th>(See musculoskeletal and skin)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skin</strong></td>
<td>• Inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, cafe-au-lait spots, ulcers) in four of the following six areas: (1) head and neck; (2) trunk; (3) right upper extremity; (4) left upper extremity; (5) right lower extremity; and (6) left lower extremity.</td>
</tr>
</tbody>
</table>

NOTE: For the comprehensive level, the examination of four anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two extremities constitutes two elements.

| Neurological/Psychiatric        | • Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the |
upper and lower extremities, evaluation of fine motor coordination in young children)

- Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski)
- Examination of sensation (e.g., by touch, pin, vibration, proprioception)
- Brief assessment of mental status including:
  - Orientation to time, place, and person
  - Mood and affect (e.g., depression, anxiety, agitation)

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Neurological Examination

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</table>
| Constitutional         | • Measurement of any three of the following seven vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (may be measured and recorded by ancillary staff)  
  • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming) |
<p>| Head and Face          |                                                                                             |
| Ears, Nose, Mouth, and Throat | • Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages) |
| Neck                   |                                                                                             |</p>
<table>
<thead>
<tr>
<th>Respiratory</th>
<th>Cardiovascular</th>
<th>Examination of carotid arteries (e.g., pulse amplitude, bruits)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Auscultation of heart with notation of abnormal sounds and murmurs</td>
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<tr>
<td></td>
<td></td>
<td>Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)</td>
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<td>Chest (Breasts)</td>
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<tr>
<td>Lymphatic</td>
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<tr>
<td>Musculoskeletal</td>
<td></td>
<td>Examination of gait and station</td>
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<tr>
<td></td>
<td></td>
<td>Assessment of motor function including:</td>
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<td></td>
<td></td>
<td>• Muscle strength in upper and lower extremities</td>
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<td></td>
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<td>• Muscle tone in upper and lower extremities (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (e.g., fasciculation, tardive dyskinesia)</td>
</tr>
<tr>
<td>Extremities</td>
<td>(See musculoskeletal)</td>
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</tr>
<tr>
<td>Skin</td>
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</tbody>
</table>
| Neurological/Psychiatric | Evaluation of higher integrative functions including:  
|                      | • Orientation to time, place, and person  
|                      | • Recent and remote memory  
|                      | • Attention span and concentration  
|                      | • Language (e.g., naming objects, repeating phrases, spontaneous speech)  
|                      | • Fund of knowledge (e.g., awareness of current events, past history, vocabulary)  
|                      | Test the following cranial nerves:  
|                      | • 2nd cranial nerve (e.g., visual acuity, visual fields, fundi)  
|                      | • 3rd, 4th, and 6th cranial nerves (e.g., pupils, eye movements)  
|                      | • 5th cranial nerve (e.g., facial sensation, corneal reflexes)  
|                      | • 7th cranial nerve (e.g., facial symmetry, strength)  
|                      | • 8th cranial nerve (e.g., hearing with tuning fork, whispered voice, and/or finger rub)  
|                      | • 9th cranial nerve (e.g., spontaneous or reflex palate movement)  |
• 11th cranial nerve (e.g., shoulder shrug strength)
• 12th cranial nerve (e.g., tongue protrusion)

• Examination of sensation (e.g., by touch, pin, vibration, proprioception)
• Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (e.g., Babinski)
• Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)

Content and Documentation Requirements

<table>
<thead>
<tr>
<th>Level of Exam</th>
<th>Perform and Document:</th>
</tr>
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<tbody>
<tr>
<td>Problem Focused</td>
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</tr>
<tr>
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<td>At least twelve elements identified by a bullet.</td>
</tr>
<tr>
<td>System/Body Area</td>
<td>Elements of Examination</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Constitutional</td>
<td>• Measurement of any three of the following seven vital signs: (1) sitting or standing</td>
</tr>
<tr>
<td></td>
<td>blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4)</td>
</tr>
<tr>
<td></td>
<td>respiration, (5) temperature, (6) height, (7) weight (may be measured and recorded by</td>
</tr>
<tr>
<td></td>
<td>ancillary staff)</td>
</tr>
<tr>
<td></td>
<td>• General appearance of patient (e.g., development, nutrition, body habitus, deformities,</td>
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<tr>
<td></td>
<td>attention to grooming)</td>
</tr>
<tr>
<td>Head and Face</td>
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<tr>
<td>Ears, Nose, Mouth,</td>
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<tr>
<td>and Throat</td>
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<tr>
<td>Neck</td>
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<tr>
<td>Respiratory</td>
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<tr>
<td>Cardiovascular</td>
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<tr>
<td>Chest (Breasts)</td>
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<tr>
<td>Gastrointestinal (Abdomen)</td>
<td></td>
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<tr>
<td>Genitourinary</td>
<td></td>
</tr>
<tr>
<td>Lymphatic</td>
<td></td>
</tr>
</tbody>
</table>
| Musculoskeletal | • Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements  
• Examination of gait and station |
| Extremities |  |
| Skin |  |
| Neurological/Psychiatric | • Description of speech including rate, volume, articulation, coherence, and spontaneity with notation of abnormalities (e.g., perseveration, paucity of language)  
• Description of thought processes including rate of thoughts, content of thoughts (e.g., logical vs. illogical, tangential), abstract reasoning, and computation  
• Description of associations (e.g., loose, tangential, circumstantial, intact) |
• Description of abnormal or psychotic thoughts including hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, and obsessions

• Description of the patient’s judgment (e.g., concerning everyday activities and social situations) and insight (e.g., concerning psychiatric condition)

• Complete mental status examination including:
  • Orientation to time, place, and person
  • Recent and remote memory
  • Attention span and concentration
  • Language (e.g., naming objects, repeating phrases)
  • Fund of knowledge (e.g., awareness of current events, past history, vocabulary)
  • Mood and affect (e.g., depression, anxiety, agitation, hypomania, lability)

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Content and Documentation Requirements

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<thead>
<tr>
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<tbody>
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<td>Problem</td>
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<tr>
<td>Focused</td>
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</tr>
</tbody>
</table>

**Expanded Problem Focused**
- At least six elements identified by a bullet.

**Detailed**
- At least nine elements identified by a bullet.

**Comprehensive**
- Perform all elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

### Respiratory Examination

<table>
<thead>
<tr>
<th>System/Body Area</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Measurement of any three of the following seven vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (may be measured and recorded by ancillary staff)</td>
</tr>
<tr>
<td></td>
<td>• General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)</td>
</tr>
<tr>
<td>Head and Face</td>
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</tr>
<tr>
<td>Eyes</td>
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</tr>
</tbody>
</table>
| **Ears, Nose, Mouth, and Throat** | • Inspection of nasal mucosa, septum, and turbinates  
• Inspection of teeth and gums  
• Examination of oropharynx (e.g., oral mucosa, hard and soft palates, tongue, tonsils, and posterior pharynx) |
| **Neck** | • Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)  
• Examination of thyroid (e.g., enlargement, tenderness, mass)  
• Examination of jugular veins (e.g., distension; a, v, or cannon a waves) |
| **Respiratory** | • Inspection of chest with notation of symmetry and expansion  
• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)  
• Percussion of chest (e.g., dullness, flatness, hyperresonance)  
• Palpation of chest (e.g., tactile fremitus)  
• Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs) |
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>• Auscultation of heart including sounds, abnormal sounds, and murmurs</td>
</tr>
<tr>
<td></td>
<td>• Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)</td>
</tr>
<tr>
<td>Chest (Breasts)</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal (Abdomen)</td>
<td>• Examination of abdomen with notation of presence of masses or tenderness</td>
</tr>
<tr>
<td></td>
<td>• Examination of liver and spleen</td>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
</tr>
<tr>
<td>Lymphatic</td>
<td>• Palpation of lymph nodes in neck, axillae, groin, and/or other location</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>• Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements</td>
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<td></td>
<td>• Examination of gait and station</td>
</tr>
<tr>
<td>Extremities</td>
<td>• Inspection and palpation of digits and nails (e.g., clubbing, cyanosis,</td>
</tr>
</tbody>
</table>
inflammation, petechiae, ischemia, infections, nodes)

<table>
<thead>
<tr>
<th>Skin</th>
<th>Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurological/Psychiatric</td>
<td>Brief assessment of mental status including:</td>
</tr>
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<td>– Mood and affect (e.g., depression, anxiety, agitation)</td>
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## Skin Examination

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<tr>
<th>System/Body Area</th>
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</table>
| Constitutional                    | - Measurement of any three of the following seven vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (may be measured and recorded by ancillary staff)  
- General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming) |
| Head and Face                     |                                                                                         |
| Eyes                              | - Inspection of conjunctivae and lids                                                   |
| Ears, Nose, Mouth, and Throat     | - Inspection of lips, teeth, and gums  
- Examination of oropharynx (e.g., oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx) |
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<thead>
<tr>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
<td>Examination of thyroid (e.g., enlargement, tenderness, mass)</td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)</td>
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<td>Chest (Breasts)</td>
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</tr>
<tr>
<td>Gastrointestinal (Abdomen)</td>
<td>Examination of liver and spleen</td>
</tr>
<tr>
<td></td>
<td>Examination of anus for condyloma and other lesions</td>
</tr>
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<td>Genitourinary</td>
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<tr>
<td>Lymphatic</td>
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<tr>
<td>Extremities</td>
<td>Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)</td>
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</tbody>
</table>
Skin

- Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area (when indicated), and extremities
- Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers, susceptibility to and presence of photo damage) in eight of the following ten areas:
  - Head, including the face
  - Neck
  - Chest, including breasts and axillae
  - Abdomen
  - Genitalia, groin, buttocks
  - Back
  - Right upper extremity
  - Left upper extremity
  - Right lower extremity
  - Left lower extremity

NOTE: For the comprehensive level, the examination of at least eight anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of the right upper extremity and the left upper extremity constitutes two elements.
- Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidrosis, or bromhidrosis

<table>
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<th>Brief assessment of mental status including:</th>
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</table>
C. Documentation of the Complexity of Medical Decision Making

The levels of E/M services recognize four types of medical decision making (straightforward, low complexity, moderate complexity, and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

The chart below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, two of the three elements in the table must be either met or exceeded.
### Each of the elements of medical decision making is described below.

**Number of Diagnoses or Management Options**

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions that are made by the physician.
Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those that are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

- **DG:** For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.
  - For a presenting problem with an established diagnosis the record should reflect whether the problem is (a) improved, well controlled, resolving, or resolved; or, (b) inadequately controlled, worsening, or failing to change as expected.
  - For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a
“possible,” “probable,” or “rule out” (R/O) diagnosis.

- **DG:** The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.
- **DG:** If referrals are made, consultations requested, or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.

**Amount and/or Complexity of Data to Be Reviewed**

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the
image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

- **DG: If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service (e.g., lab or X-ray) should be documented.**

- **DG: The review of lab, radiology, and/or other diagnostic tests should be documented. A simple notation such as “WBC elevated” or “chest X-ray unremarkable” is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.**

- **DG: A decision to obtain old records or a decision to obtain additional history from the family, caretaker, or other source to supplement that obtained from the patient should be documented.**

- **DG: Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker, or other source to supplement that obtained from the patient should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of “old
records reviewed” or “additional history obtained from family” without elaboration is insufficient.

• **DG:** The results of discussion of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study should be documented.

• **DG:** The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.

**Risk of Significant Complications, Morbidity, and/or Mortality**
The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

• **DG:** Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.

• **DG:** If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of
procedure (e.g., laparoscopy) should be documented.

- **DG:** If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.

- **DG:** The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is minimal, low, moderate, or high. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.
<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| Minimal       | • One self-limited or minor problem (e.g., cold, insect bite, tinea corporis) | • Laboratory tests requiring venipuncture  
• Chest X-rays  
• EKG/EEG  
• Urinalysis  
• Ultrasound (e.g., echocardiography)  
• KOH prep | • Rest  
• Gargles  
• Elastic bandages  
• Superficial dressings |
| Low           | • Two or more self-limited or minor problems  
• One stable chronic illness (e.g., well-controlled hypertension, noninsulin-dependent diabetes, cataract, BPH)  
• Acute uncomplicated illness or injury (e.g., cystitis, | • Physiologic tests not under stress (e.g., pulmonary function tests  
• Noncardiovascular imaging studies with contrast, (e.g., barium enema)  
• Superficial needle biopsies  
• Clinical laboratory tests requiring arterial puncture  
• Skin biopsies | • Over-the-counter drugs  
• Minor surgery with no identified risk factors  
• Physical therapy  
• Occupational therapy  
• IV fluids without additives |
<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
<th>Moderate</th>
<th>Physiologic tests under stress (e.g., cardiac stress test, fetal contraction stress test)</th>
<th>Diagnostic endoscopies with no identified risk factors</th>
<th>Minor surgery with identified risk factors</th>
<th>Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors</th>
<th>Prescription drug management</th>
<th>Cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization)</th>
<th>IV fluids with additives</th>
<th>Closed treatment of fracture or dislocation without manipulation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Allergic rhinitis, simple sprain</td>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>Physiologic tests under stress (e.g., cardiac stress test, fetal contraction stress test)</td>
<td>Diagnostic endoscopies with no identified risk factors</td>
<td>Minor surgery with identified risk factors</td>
<td>Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors</td>
<td>Prescription drug management</td>
<td>Cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization)</td>
<td>IV fluids with additives</td>
<td>Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td>Medicine</td>
<td>Illusion related to the perception of injury or illness (e.g., phantom pain)</td>
<td>Moderate</td>
<td>Physiologic tests under stress (e.g., cardiac stress test, fetal contraction stress test)</td>
<td>Diagnostic endoscopies with no identified risk factors</td>
<td>Minor surgery with identified risk factors</td>
<td>Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors</td>
<td>Prescription drug management</td>
<td>Cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization)</td>
<td>IV fluids with additives</td>
<td>Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td></td>
<td>Chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>Moderate</td>
<td>Physiologic tests under stress (e.g., cardiac stress test, fetal contraction stress test)</td>
<td>Diagnostic endoscopies with no identified risk factors</td>
<td>Minor surgery with identified risk factors</td>
<td>Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors</td>
<td>Prescription drug management</td>
<td>Cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization)</td>
<td>IV fluids with additives</td>
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</tr>
<tr>
<td></td>
<td>Two or more stable chronic illnesses</td>
<td>Moderate</td>
<td>Physiologic tests under stress (e.g., cardiac stress test, fetal contraction stress test)</td>
<td>Diagnostic endoscopies with no identified risk factors</td>
<td>Minor surgery with identified risk factors</td>
<td>Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors</td>
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</tr>
<tr>
<td></td>
<td>Undiagnosed new problem with uncertain prognosis (e.g., lump in breast)</td>
<td>Moderate</td>
<td>Physiologic tests under stress (e.g., cardiac stress test, fetal contraction stress test)</td>
<td>Diagnostic endoscopies with no identified risk factors</td>
<td>Minor surgery with identified risk factors</td>
<td>Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors</td>
<td>Prescription drug management</td>
<td>Cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization)</td>
<td>IV fluids with additives</td>
<td>Closed treatment of fracture or dislocation without manipulation</td>
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<tr>
<td></td>
<td>Acute illness with systemic symptoms (e.g., pyelonephritis, pneumonitis, colitis)</td>
<td>Moderate</td>
<td>Physiologic tests under stress (e.g., cardiac stress test, fetal contraction stress test)</td>
<td>Diagnostic endoscopies with no identified risk factors</td>
<td>Minor surgery with identified risk factors</td>
<td>Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors</td>
<td>Prescription drug management</td>
<td>Cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization)</td>
<td>IV fluids with additives</td>
<td>Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td></td>
<td>Acute complicated injury (e.g., head injury with brief loss)</td>
<td>Moderate</td>
<td>Physiologic tests under stress (e.g., cardiac stress test, fetal contraction stress test)</td>
<td>Diagnostic endoscopies with no identified risk factors</td>
<td>Minor surgery with identified risk factors</td>
<td>Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors</td>
<td>Prescription drug management</td>
<td>Cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization)</td>
<td>IV fluids with additives</td>
<td>Closed treatment of fracture or dislocation without manipulation</td>
</tr>
</tbody>
</table>
| High | • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment  
• Acute or chronic illnesses or injuries that pose a threat to life or bodily function (e.g., multiple trauma, acute renal failure)  
• MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat | • Cardiovascular imaging studies with contrast with identified risk factors  
• Cardiac electrophysiological tests  
• Diagnostic endoscopies with identified risk factors  
• Discography | • Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors  
• Emergency major surgery (open, percutaneous, or endoscopic)  
• Parenteral controlled substances  
• Drug therapy requiring intensive monitoring for toxicity  
• Decision not to resuscitate or to deescalate care because of poor prognosis |
to self or others, peritonitis, acute renal failure
- An abrupt change in neurologic status (e.g., seizure, TIA, weakness, sensory loss)

D. Documentation of an Encounter Dominated by Counseling or Coordination of Care

In the case where counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

- **DG:** *If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented, and the record should describe*
the counseling and/or activities to coordinate care.

Note
Chapter 5: Prescribing

Nurse practitioners (NPs) in 50 states and the District of Columbia have the legal authority to prescribe. The independence of NPs’ prescriptive authority varies widely, and, in several states, words other than “prescribe” are used.

In 25 states and the District of Columbia, experienced NPs have explicit legal authority to “prescribe,” with no requirement for physician involvement. In five of these states, there is an initial period of 2 to 3 years after graduation that an NP must be mentored, before obtaining full prescriptive authority. In 24 states, NPs have explicit legal authority to prescribe but must have a collaborative relationship with a specific physician. In one state (Utah), NPs need physician involvement only if operating a pain clinic. (See Exhibit 5-1.) In all states and the District of Columbia, NPs may prescribe controlled substances. In some states, there are restrictions on Schedule II drugs. (See Exhibit 5-2 for the states that fall into this category.)
Appendix 5-A presents laws on prescriptive authority for each state.

**Controlled Substances**

Controlled dangerous substances are narcotics, depressants, stimulants, and hallucinogenic drugs covered under the Controlled Substances Act, a federal law. In all states and the District of Columbia, NPs may prescribe controlled substances. In at least six states, NPs must complete regular continuing education on the prescribing of controlled drugs. Among the states with these continuing education requirements are California, Kentucky, Mississippi, Tennessee, Texas, and South Carolina.

**Classification of Controlled Substances**

There are five “schedules” of controlled substances:

- **Schedule I**: Schedule I substances have no accepted medical use in the United States and have high abuse potential. Examples are heroin, LSD, MDMA (“ecstasy”), marijuana, and peyote.
- **Schedule II**: Schedule II drugs have a high abuse potential with severe psychic or physical dependence liability and in general are substances that have therapeutic utility.
Schedule II narcotics include morphine, codeine, fentanyl, hydrocodone, hydromorphone (Dilaudid), meperidine (Demerol), methadone, pantopon, and opium. Stimulants such as amphetamines are included in Schedule II, as well as depressants such as pentobarbital.

- **Schedule III**: Schedule III drugs are stimulants and depressants with an abuse potential that is less than those drugs in Schedules I and II. Schedule III narcotics include mixtures of limited specified quantities of codeine with noncontrolled active ingredients (such as Tylenol with codeine) and mixtures of amobarbital, pentobarbital, or secobarbital with other noncontrolled medicinal ingredients.

- **Schedule IV**: Schedule IV drugs have less abuse potential than Schedule III and include depressants such as alprazolam, phenobarbital, and chloral hydrate.

- **Schedule V**: Schedule V substances have less abuse potential than Schedule IV and include preparations containing limited quantities of certain narcotic and stimulant drugs generally given for antitussive, antidiarrheal, and analgesic purposes. Examples are buprenorphine and propylhexedrin.

A complete listing of the drugs controlled under the Controlled Substances Act may be found in Title 21,
Code of Federal Regulations, Part 1300 to end, Sections 1308.11 through 1308.15. Prescribing references usually provide the class of each drug listed.

<table>
<thead>
<tr>
<th></th>
<th>Explicit Legal Authority to Prescribe/No Physician Involvement Required*</th>
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<tbody>
<tr>
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<td>Alaska</td>
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<td>Arizona</td>
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<td>Maryland</td>
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<td>Michigan (nonscheduled drugs)</td>
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<td>Minnesota</td>
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<td></td>
<td>Montana</td>
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</table>

|                      | Physician May Delegate Authority to Prescribe                                  |
|                      | Georgia                                                                        |
|                      | Michigan (controlled drugs)                                                   |
|                      | Texas                                                                          |

<p>|                      | Explicit Legal Authority to Prescribe/Physician Collaboration Required         |
|                      | Alabama                                                                        |
|                      | Arkansas                                                                       |
|                      | California                                                                     |
|                      | Delaware                                                                       |
|                      | Florida                                                                        |
|                      | Georgia                                                                        |
|                      | Illinois                                                                       |
|                      | Indiana                                                                        |
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|                      | Louisiana                                                                      |</p>
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<th>State</th>
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<td>Nebraska</td>
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<td>Rhode Island</td>
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<td>South Dakota</td>
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<td>Utah†</td>
<td>Pennsylvania</td>
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<td>Vermont†</td>
<td>South Carolina</td>
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<td>Washington</td>
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<td>West Virginia†</td>
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<td>Wyoming</td>
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<td>Wisconsin</td>
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* In some states, an initial period of collaborative practice may be required prior to being authorized to practice independently.

† After completion of required mentorship hours or years. In addition, Utah requires physician involvement if NP is operating a pain clinic.

Exhibit 5-2 State Regulations of NPs’ Prescriptive Authority for Controlled Drugs
<table>
<thead>
<tr>
<th>NP May Prescribe Controlled Substances (except Schedule I, which are not used medically)</th>
<th>Mississippi</th>
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</thead>
<tbody>
<tr>
<td>Alabama (Not Schedule II)</td>
<td>Missouri (Not Schedule II)</td>
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<tr>
<td>Alaska</td>
<td>Montana</td>
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<tr>
<td>Arizona</td>
<td>Nebraska</td>
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<tr>
<td>Arkansas (Not Schedule II)</td>
<td>Nevada</td>
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<tr>
<td>California</td>
<td>New York</td>
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<td>Colorado</td>
<td>New Jersey</td>
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<td>Connecticut</td>
<td>New Mexico</td>
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<td>Delaware</td>
<td>New Hampshire</td>
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<tr>
<td>District of Columbia</td>
<td>North Carolina</td>
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<tr>
<td>Florida (Limitations on Schedule II)</td>
<td>North Dakota</td>
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<tr>
<td>Georgia (Not Schedule II)</td>
<td>Ohio</td>
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<td>Hawaii</td>
<td>Oklahoma (Not Schedule II)</td>
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<td>Idaho</td>
<td>Oregon</td>
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<td>Illinois</td>
<td>Pennsylvania</td>
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<tr>
<td>Indiana</td>
<td>Rhode Island</td>
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<tr>
<td>Iowa</td>
<td>South Carolina (Not Schedule II)</td>
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<td>Kansas</td>
<td>South Dakota</td>
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<td>Kentucky</td>
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<td>Louisiana (Not Schedule II, except for attention deficit disorder)</td>
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<td>Maine</td>
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<td>Maryland</td>
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<td>Michigan</td>
<td>Texas (Not Schedule II)</td>
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<td>Minnesota</td>
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<td>Vermont</td>
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<td>Washington</td>
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<td>West Virginia (Not Schedule II)</td>
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<td>Wisconsin</td>
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<td>Wyoming</td>
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**Drug Enforcement Administration Registration**

The federal government—the Drug Enforcement Administration (DEA)—oversees NPs’ prescribing of controlled substances. To prescribe controlled substances, an NP must register with the DEA and obtain a DEA number. The NP must use the DEA number on prescriptions for scheduled drugs.

DEA registration is one method of tracking healthcare providers’ prescribing practices related to controlled substances. The DEA number is also a method of minimizing unauthorized prescribing; a
person who is not authorized to prescribe but who wants to write a prescription for a controlled substance, has a prescription pad, and signs the name of an authorized prescriber will be unable to get the prescription filled if it does not include a DEA number.

Federal registration is based on the applicant’s compliance with state and local laws. If a state requires a separate controlled substances license, an NP must obtain that license and submit a copy with the application for a DEA number. If state law does not authorize NPs to prescribe controlled substances, the DEA will not issue DEA numbers.

DEA registration costs $731 for a 3-year term. States may charge for registration as well. To apply for DEA registration, visit the DEA’s website. Once a DEA number has been issued, a renewal application is automatically issued 45 days prior to expiration. Registrants must report, in writing, any change in business location to the DEA. DEA registration is issued in the NP’s name at the business address.

Guidelines for Prescribing Legally
NPs should follow these general guidelines when prescribing:
1. Prescribe the right medicine at the right time for the right indication for the right patient.

2. If there is a practice protocol or guidelines in the facility, follow it.

3. If there is no facility-wide protocol, adhere to the standard of care in prescribing. The standard of care for prescribing may be assumed to be the *Physician’s Desk Reference* or Epocrates ([http://www.epocrates.com](http://www.epocrates.com)) for indication, dose, and side effects, and one of the state, agency, or organization guidelines for prescribing opioids for chronic pain. Examples of guidelines for prescribing opioids are:
   - Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain (2016)
   - American Academy of Neurology, Opioids for Chronic Noncancer Pain (2014)
   - Oklahoma Opioid Prescribing Guidelines (2014)²

4. Before prescribing, ask a patient:
   - Are you pregnant? Are you trying to be?
   - Are you breastfeeding?
   - Are you allergic to any medications?
Have you taken [this medicine] before? Did it work? Did it give you any ill effects?
Do you have any liver or kidney problems?
What other medications are you on?
What other medical problems do you have?
Before prescribing an opioid or other controlled drug, ask additional questions to assess the patient’s need and current function and to determine whether a patient is at high-risk for abuse. Among the questions to ask are:
What number from 0–10 best describes your pain in the past week?
What number from 0–10 describes how, during the past week, pain has interfered with your enjoyment of life?
What number from 0–10 describes how, during the past week, pain has interfered with your general activity?
Evaluate the patient’s underlying condition to determine the need for pain medication.
How often in the past 5 years have you taken pain medication? What did you take?
Have you taken a nonsteroidal medication for this pain? How effective was it?
- Have you tried to decrease your pain through any means other than medications?
- In the past, have you taken any medications or drugs that were not prescribed specifically for you?
- Are you willing to sign a contract in which you agree to get prescriptions from only me, to give me 72 hours notice before you need a refill, to consent to and undergo random urine screens, and to use only one pharmacy?

To assess risk of abuse, utilize the “Opioid Risk Tool,” available online. Check the state Prescription Drug Monitoring Program database to see whether the patient is registered there and to determine what medications, if any, he or she has been getting from other providers. Before prescribing an opioid medication, perform a urine drug screen to determine whether the patient has controlled drugs in his or her system.

5. Address any cross-sensitivities. For example, if a patient is allergic to penicillin, an NP probably should not prescribe Keflex, which has cross-sensitivities with penicillin.
6. Address any contraindications. For example, a patient with chronic hepatitis should not be prescribed a medication that has potential for liver damage unless it is a life or death situation and there is no other choice.

7. Address any drug interactions. For example, theophylline is antagonized by phenytoin and potentiated by macrolide antibiotics.

8. Inform the patient of potential side effects, and ask whether the patient wants to accept the risk of experiencing those side effects.

9. Instruct the patient to call or return if he or she notices any adverse change in his or her condition.

Other considerations when prescribing include the following:

- Can the patient afford the medication? If not, the NP should not count on the patient’s getting the prescription filled.
- Is the drug to be prescribed in the formulary for the agency or health maintenance organization?
- Is there potential for abuse of the medication? For example, a depressed patient may overdose on a prescribed medication, and a patient with a history of substance abuse may be seeking to
continue the habit through a request for pain medication.

- Can the patient read? For example, the author had a personal experience where a patient was not responding to a variety of blood pressure medications. After much trial and error as well as discussion, it was revealed that the patient was not literate. The patient kept his wide assortment of medications on top of the refrigerator. He depended on his wife to dole out the proper medication to him, at the proper time and in the proper dose. When she was not available, which was often, he did not get his medication.

Notes


Resource

Appendix 5-A State-by-State Law Prescriptive Authority

Alabama

[The] joint committee shall recommend model practice protocols to be used by certified registered nurse practitioners and certified nurse midwives and a formulary of legend drugs that may be prescribed by these advanced practice nurses, subject to approval by both the State Board of Medical Examiners and the Board of Nursing. The joint committee shall also recommend rules and regulations to establish the ratio of physicians to certified registered nurse practitioners and certified nurse midwives; provided, however, that the rules and regulations shall not limit the ratio to less than two nurse practitioners or midwives to one physician or one certified registered nurse practitioner and one certified nurse midwife to one physician and
shall provide for exceptions. The joint committee shall also recommend rules and regulations that establish the manner in which a collaborating physician may designate a covering physician when temporarily unavailable as the collaborating physician.

*Citation: ALA. CODE § 34-21-87.*

a. Certified registered nurse practitioners and certified nurse midwives, engaged in collaborative practice with physicians practicing under protocols approved in the manner prescribed by this article may prescribe legend drugs to their patients, subject to both of the following conditions:

1. The drug type, dosage, quantity prescribed, and number of refills shall be authorized in an approved protocol signed by the collaborating physician; and

2. The drug shall be on the formulary recommended by the joint committee and adopted by the State Board of Medical Examiners and the Board of Nursing.
b. A certified registered nurse practitioner or a certified nurse midwife may not initiate a call-in prescription in the name of a collaborating physician for any drug, whether legend or controlled substance, which the nurse practitioner or certified nurse midwife is not authorized to prescribe under the protocol signed by the collaborating physician and certified registered nurse practitioner or certified nurse midwife and approved under this section unless the drug is specifically ordered for the patient by the physician, either in writing or by a verbal order which has been reduced to writing, and which has been signed by the physician within a time specified in the rules and regulations approved by the State Board of Medical Examiners and the Board of Nursing.

c. Registered nurses and licensed practical nurses are authorized to administer any legend drug that has been lawfully ordered or prescribed by an authorized practitioner including certified registered nurse practitioners, certified nurse midwives, and/or assistants to physicians.

Citation: Ala. Code § 34-21-86.
1. Certified registered nurse practitioners engaged in collaborative practice with physicians may be granted prescriptive authority upon submission of evidence of completion of an academic course in pharmacology or evidence of integration of pharmacology theory and clinical application in the certified registered nurse practitioner curriculum.

2. Certified registered nurse practitioners practicing under protocols approved in the manner prescribed by Code of Alabama, 1975, Section 34-21-80 et seq. may prescribe legend drugs to their patients, subject to the following conditions:
   a. The drug shall be included in the formulary recommended by the Joint Committee and adopted by the Board of Nursing and the State Board of Medical Examiners.
   b. The drug type, dosage, quantity prescribed, and number of refills shall be authorized in an approved protocol signed by the collaborating physician and the certified registered nurse practitioner. This requirement may be met if written prescriptions adhere to the standard recommended doses of
legend drugs as identified in the Physician’s Desk Reference or Product Information Insert, and do not:

i. Exceed the recommended treatment regimen periods.

ii. Include United States Food and Drug Administration (FDA) non-approved supplements, drug products, medication, and off label medications.

c. Drugs and medications that do not have FDA approval may be prescribed through protocol registration in a United States Institutional Review Board or Expanded Access authorized clinical trial.

d. “Off Label” use or prescription of FDA-approved medications for uses other than that indicated by the FDA, is permitted when such practices are:

i. Within the standard of care for treatment of disease or condition.

ii. Supported by evidence-based research.

iii. Approved by the collaborating physician and entered into the
patient record.

3. A certified registered nurse practitioner shall not initiate a call-in prescription in the name of a collaborating physician for any drug, whether legend or controlled substance, which the certified registered nurse practitioner is not authorized to prescribe under the protocol signed by the collaborating physician and certified registered nurse practitioner and approved under this section unless the drug is specifically ordered for the patient by the physician, either in writing or by a verbal order which has been transcribed in writing, and which has been signed by the physician within seven working days or as otherwise specified by the Board of Nursing and the State Board of Medical Examiners.

4. A written prescription for any drug that the certified registered nurse practitioner is authorized to prescribe may be called in to a pharmacy, provided the prescription is entered into the patient’s record and signed by the certified registered nurse practitioner.

5. The certified registered nurse practitioner in collaborative practice with prescriptive privileges shall not engage in prescribing for:
   a. Self.
b. Immediate family members.

c. Individuals who are not patients of the practice.

6. The certified registered nurse practitioner who is in collaborative practice and has prescriptive privileges may receive and sign for samples of legend drugs that are authorized in the approved formulary for the collaborative practice, provided the certified registered nurse practitioner complies with all applicable state and federal laws and regulations.

7. When prescribing legend drugs a certified registered nurse practitioner shall use a prescription format that includes all of the following:

   a. The name, medical practice site address and telephone number of the collaborating physician or covering physician.

   b. The certified registered nurse practitioner’s name printed below or to the side of the physician’s name.

   c. The medical practice site address and telephone number of the certified registered nurse practitioner if different from that of the collaborating physician.
d. The certified registered nurse practitioner’s registered nurse license number and identifying prescriptive authority number assigned by the Board of Nursing.

e. The words “Product Selection Permitted” printed on one side of the prescription form directly beneath a signature line.

f. The words “Dispense as written” printed on one side of the prescription form directly beneath a signature line.

g. The date the prescription is issued to the patient.

_Citation: A LA. ADMIN. CODE r. 610-X-5-.12._

Upon receipt of a Qualified Alabama Controlled Substances Registration Certificate (QACSC) and a valid registration number issued by the United States Drug Enforcement Administration, a certified registered nurse practitioner (CRNP) or certified nurse midwife (CNM) may prescribe, administer, authorize for administration, or dispense only those controlled substances listed in Schedules III, IV, and V of Article 2, Chapter 2, of this title in accordance with rules adopted by the Board of Medical Examiners and any protocols, formularies, and
medical regimens established by the board for regulation of a QACSC.

Citation: ALA. CODE § 20-2-253(a).

Alaska

a. The Board will, in its discretion, authorize an advanced nurse practitioner or “ANP” to prescribe and dispense legend drugs in accordance with applicable state and federal laws.

c. An advanced nurse practitioner who applies for authorization to prescribe and dispense drugs

1. must be currently designated as an ANP in Alaska at the time of application;

2. shall provide evidence of completion of 15 contact hours of education in advanced pharmacology and clinical management of drug therapy within the two-year period immediately before the date of application; and

3. shall submit a completed application, as required in 12 AAC 44.400(a)(6)
accompanied by the application fee established by 12 AAC 02.280.

h. In this section, “prescriptive authority” includes authority to dispense prescriptions.

*Citation: Alaska Admin. Code tit. 12, § 44.440.*

*There is no requirement for physician collaboration.*

a. In addition to the legend drug prescriptive and dispensing authority under 12 AAC 44.440, the board will, in its discretion, authorize an advanced nurse practitioner or “ANP” to prescribe and dispense schedule 2-5 controlled substances in accordance with applicable state and federal laws if an applicant

1. submits a completed application on a form provided by the department; the completed application must include the applicant’s
   A. name, address, and phone number;
   B. authorization number as an ANP;
   C. date of birth; and
D. notarized signature certifying that the information in the application is correct to the best of the applicant’s knowledge;

b. All the provisions of 12 AAC 44.440 apply to an ANP with controlled substance prescriptive authority under this section; and
   3. pays the application fee established by 12 AAC 02.280.

Citation: ALASKA ADMIN. CODE tit. 12, § 44.445.

Arizona
A. The Board shall authorize an RNP to prescribe and dispense (P & D) drugs and devices within the RNP’s population focus only if the RNP does all of the following:
   1. Obtains authorization by the Board to practice as a registered nurse practitioner;
   2. Applies for prescribing and dispensing privileges on the application for registered nurse practitioner certification;
   3. Submits a completed verified application on a form provided by the
Board that contains all of the following information:

a. Name, address, e-mail address and home telephone number;
b. Arizona registered nurse license number, or copy of compact license;
c. Nurse practitioner population focus;
d. Nurse practitioner certification number issued by the Board; and
e. Business address and telephone number;

4. Submits evidence of a minimum of 45 contact hours of education within the three years immediately preceding the application, covering one or both of the following topics consistent with the population focus of education and certification:
   a. Pharmacology, or
   b. Clinical management of drug therapy, and

5. Submits the required fee.
A. An RNP granted P & D authority by the Board may:
   1. Prescribe drugs and devices;
   2. Provide for refill of prescription-only drugs and devices for one year from the date of the prescription.

B. An RNP with P & D authority who wishes to prescribe a controlled substance shall obtain a DEA registration number before prescribing a controlled substance. The RNP shall file the DEA registration number with the Board.

C. An RNP with a DEA registration number may prescribe:
   1. A Schedule II controlled substance as defined in the federal Controlled Substances Act, 21 U.S.C. § 801 et seq., or Arizona’s Uniform Controlled Substances Act, A.R.S. Title 36, Chapter 27, but shall not prescribe refills of the prescription;
   2. A Schedule III or IV controlled substance, as defined in the federal Controlled Substances Act or Arizona’s Uniform Controlled Substances Act,
and may prescribe a maximum of five refills in six months; and

3. A Schedule V controlled substance, as defined in the federal Controlled Substances Act or Arizona’s Uniform Controlled Substances Act, and may prescribe refills for a maximum of one year.

D. An RNP whose DEA registration is revoked or expires shall not prescribe controlled substances. An RNP whose DEA registration is revoked or limited shall report the action to the Board.

E. In all outpatient settings or at the time of hospital discharge, an RNP with P & D authority shall personally provide a patient or the patient’s representative with the name of the drug, directions for use, and any special instructions, precautions, or storage requirements necessary for safe and effective use of the drug if any of the following occurs:

1. A new drug is prescribed or there is a change in the dose, form, or direction for use in a previously prescribed drug;

2. In the RNP’s professional judgment, these instructions are warranted; or
3. The patient or patient’s representative requests instruction.

F. An RNP with P & D authority shall ensure that all prescription orders contain the following:
   1. The RNP’s name, address, telephone number, and population focus;
   2. The prescription date;
   3. The name of the patient and either the address of the patient or a blank for the address if the prescription is not being dispensed by the RNP;
   4. The full name of the drug, strength, dosage form, and directions for use;
   5. The letters “DAW,” or “dispense as written,” “do not substitute,” “medically necessary” or any similar statement on the face of the prescription form if intending to prevent substitution of the drug;
   6. The RNP’s DEA registration number, if applicable; and
   7. The RNP’s signature.

Citation: ARIZ. ADMIN. CODE R4-19-512.

Arkansas
The Arkansas State Board of Nursing may grant a certificate of prescriptive authority to an advanced practice nurse who:

1. Submits proof of successful completion of a Board-approved advanced pharmacology course that shall include preceptorial experience in the prescription of drugs, medicine, and therapeutic devices; and

2. Has a collaborative practice agreement with a practicing physician who is licensed under the Arkansas Medical Practices Act, §§ 17-95-201–17-95-207, 17-95-301–17-95-305, and 17-95-401–17-95-411, and who has training in scope, specialty or expertise to that of the advanced practice registered nurse on file with the Board.

Citation: ARK. CODE ANN. § 17-87-310(a).

An advanced practice registered nurse with a certificate of prescriptive authority may receive and prescribe drugs, medicines, or therapeutic devices appropriate to the advanced practice registered nurse’s area of practice in accordance with rules established by the Board.

Citation: ARK. CODE ANN. § 17-87-310(b)(1).
An advanced practice registered nurse’s prescriptive authority shall extend only to drugs listed in Schedules III–V and, if expressly authorized by the collaborative practice agreement, also to those hydrocodone combination products reclassified from Schedule III to Schedule II as of October 6, 2014.

*Citation:* ARK. CODE ANN. § 17-87-310(b)(2).

**California**

Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing or ordering drugs or devices when all of the following apply:

a. The drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon when the drugs or devices furnished or ordered are consistent with the nurse practitioner’s educational preparation or for which clinical competency has been established and maintained.

b. The nurse practitioner is functioning pursuant to standardized procedure, as defined by
Section 2725, or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator or the designee.

c.

1. The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioner may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner’s competence, including peer review, and review of the provisions of the standardized procedure.

2. In addition to the requirements in paragraph (1), for Schedule II controlled substance protocols, the provision for furnishing Schedule II controlled substances shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.
d. The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include: (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner.

e. For purposes of this section, no physician and surgeon shall supervise more than four nurse practitioners at one time.

f.  
   1. Drugs or devices furnished or ordered by a nurse practitioner may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act . . . and shall be further limited to those drugs agreed upon by the nurse practitioner and physician and surgeon and specified in the standardized procedure.
   2. When Schedule II or III controlled substances . . . are furnished or ordered by a nurse practitioner, the
controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the nurse practitioner’s standardized procedure relating to controlled substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner furnishing the order.

g.

1. The board has certified in accordance with Section 2836.3 that the nurse practitioner has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section.

2. A physician and surgeon may determine the extent of supervision necessary pursuant to this section in the furnishing or ordering of drugs and devices.

3. Nurse practitioners, who are certified by the board and hold an active furnishing number, who are authorized
through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration, shall complete, as part of their continuing education requirements, a course including Schedule II controlled substances based on the standards developed by the board. The board shall establish the requirements for satisfactory completion of this subdivision.

h. Use of the term “furnishing” in this section, in health facilities defined in Section 1250 of the Health and Safety Code, shall include (1) the ordering of a drug or device in accordance with the standardized procedure and (2) transmitting an order of a supervising physician and surgeon.

i. “Drug order” or “order,” for purposes of this section, means an order for medication which is dispensed to or for an ultimate user, issued by a nurse practitioner as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other
provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to “prescription” in this code and the Health and Safety Code shall include drug orders issued by nurse practitioners; and (3) the signature of a nurse practitioner on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

*Citation:* Cal. Bus. & Prof. Code § 2836.1.

Furnishing or ordering of drugs or devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure. All nurse practitioners who are authorized pursuant to Section 2836.1 to furnish or issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration.

*Citation:* Cal. Bus. & Prof. Code § 2836.2.

**Colorado**
The board may authorize an advanced practice nurse who is listed on the advanced practice registry, has a license in good standing without disciplinary sanctions issued pursuant to Section 12-38-111, and has fulfilled requirements established by the board pursuant to this section to prescribe controlled substances or prescription drugs as defined in part 1 of article 42.5 of this title.

_Citation:_ **COLO. REV. STAT. ANN.** § 12-38-111.6(1).

For detailed requirements, see additional language in Colo. Rev. Stat. Ann. § 12-38-111.6 and the Colorado Board of Nursing Rules, ch. 15.

**Connecticut**

An advanced practice registered nurse having been issued a license pursuant to section 20-94a shall, for the first three years after having been issued such license, collaborate with a physician licensed to practice medicine in this state. In all settings, such advanced practice registered nurse may, in collaboration with a physician licensed to practice medicine in this state, prescribe, dispense, and administer medical therapeutics and corrective measures and may request, sign for, receive, and dispense drugs in the form of professional samples. . . . Relative to the exercise of prescriptive authority,
the collaboration between such advanced practice registered nurse and a physician shall be in writing and shall address the level of schedule II and III controlled substances that such advanced practice registered nurse may prescribe and provide a method to review patient outcomes, including, but not limited to, the review of medical therapeutics, corrective measures, laboratory tests and other diagnostic procedures that such advanced practice registered nurse may prescribe, dispense and administer.


An advanced practice registered nurse having (A) been issued a license pursuant to section 20-94a, (B) maintained such license for a period of not less than three years, and (C) engaged in the performance of advanced practice level nursing activities in collaboration with a physician for a period of not less than three years and not less than two thousand hours in accordance with the provisions of subdivision (2) of this subsection, may, thereafter, alone or in collaboration with a physician or another health care provider licensed to practice in this state: (i) Perform the acts of diagnosis and treatment of alterations in health status, as described in subsection (a) of this section; and (ii)
prescribe, dispense and administer medical therapeutics and corrective measures and dispense drugs in the form of professional samples as described in subdivision (2) of this subsection in all settings.

*Citation: CONN. GEN. STAT. ANN. § 20-87a(b)(3).*

**Delaware**

An APRN licensed by the Board may prescribe, order, procure, administer, store, dispense and furnish over the counter, legend and controlled substances pursuant to applicable state and federal laws and within the APRN’s role and population focus.

1. Written, verbal or electronic prescriptions and orders shall comply with all applicable state and federal laws.

2. All prescriptions shall be clearly written, clearly hand-printed, electronically printed, or typed and shall include, but not be limited to, the following information:
   a. The name, title, address, phone number, and registration number of the prescriber;
   b. Name of patient;
   c. Date of prescription;
d. Full name of the drug, dosage, route, amount to be dispensed and directions for its use;

e. Number of refills;

f. Signature of prescriber on written prescription;

g. DEA number of the prescriber on all scheduled drugs.

3. APRNs may receive, sign for, record and distribute samples to patients. Distribution of drug samples shall be in accordance with state law and federal Drug Enforcement Administration laws, regulations and guidelines.

_Citation:_ Del. Code Ann. tit. 24, § 1927.

Those individuals who wish to engage in independent practice without written guidelines or protocols and/or wish to have independent prescriptive authority shall apply for such privilege or privileges to the Joint Practice Committee and do so only in collaboration with a licensed physician, dentist, podiatrist, or licensed Delaware health-care delivery system. This does not include those individuals who have protocols and/or waivers
approved by the Board of Medical Licensure and Discipline.

_Citation_: _Del. Code_ Ann. tit. 24, § 1902(c)(1)(b).

The “Joint Practice Committee” with the approval of the Board of Medical Licensure and Discipline, shall have the authority to grant, restrict, suspend, or revoke practice or independent practice authorization, and the Joint Practice Committee with the approval of the Board of Medical Licensure and Discipline shall be responsible for promulgating rules and regulations to implement the provisions of this chapter regarding “advanced practice nurses” who have been granted authority for independent practice and/or independent prescriptive authority.

_Citation_: _Del. Code_ Ann. tit. 24, § 1906(20).

APNs may prescribe, administer, and dispense legend medications including Schedule II–V controlled substances, (as defined in the Controlled Substance Act and labeled in compliance with 24 Del.C. §2536(C), parenteral medications, medical therapeutics, devices and diagnostics.

_Citation_: _Del. Admin. Code_, tit. 24, §8.18.1.
District of Columbia

An advanced practice registered nurse may initiate, monitor, and alter drug therapies.

Citation: D.C. STAT. § 3-1206.04(1).

The advanced practice registered nurse may perform actions of medical diagnosis, treatment, prescription, and other functions authorized by this subchapter.

Citation: D.C. STAT. § 3-1206.01.

1. A nurse-practitioner shall have authority to prescribe legend drugs and controlled substances subject to the limitations set forth in § 5910.
2. A nurse-practitioner shall have authority to prescribe drugs only while certified in accordance with this chapter.
3. Prescriptions for drugs shall comply with all applicable District of Columbia and federal laws.
4. A nurse-practitioner who administers or prescribes a prescription drug shall enter in the patient’s chart on the date of the transaction or, if the chart is not available, no
later than the next office day, the following information:

a. Each prescription that a nurse-practitioner orders; and
b. The name, strength, and amount of each drug that a nurse-practitioner administers.

Citation: D.C. MUNICIPAL REGS. § 17-5909.

A nurse-practitioner shall have authority to prescribe those drugs on Schedules II through V established pursuant to the District of Columbia Uniform Controlled Substances Act of 1981, D.C. Law 4-29, D.C. Code §§ 33-501 et seq., that are authorized by the protocol under which the nurse-practitioner is practicing.

Citation: D.C. MUNICIPAL REGS. § 17-5910.1.

A nurse-practitioner shall not prescribe a controlled substance unless a licensed, certified nurse practitioner meets the following requirements:

a. Possesses a valid controlled substances certificate of registration from the United States Drug Enforcement Administration (DEA); and

*Citation:* D.C. MUNICIPAL REGS. § 17-5910.2.

A nurse-practitioner shall not issue a refillable prescription for a controlled substance.

*Citation:* D.C. MUNICIPAL REGS. § 17-5910.3.

**Florida**

3. An advanced registered nurse practitioner shall perform those functions authorized in this section within the framework of an established protocol that is filed with the board upon biennial license renewal and within 30 days after entering into a supervisory relationship with a physician or changes to the protocol.

a. Prescribe, dispense, administer, or order any drug; however, an advanced registered nurse practitioner may prescribe or dispense a controlled substance as defined in s. 893.03 only if the advanced registered nurse
practitioner has graduated from a program leading to a master’s or doctoral degree in a clinical nursing specialty area with training in specialized practitioner’s skills.

7a. The board shall establish a committee to recommend a formulary of controlled substances that an advanced registered nurse practitioner may not prescribe or may prescribe only for specific uses or in limited quantities . . . . The formulary must . . . limit the prescribing of Schedule II controlled substances as listed in s. 893.03 to a 7-day supply, . . .

*Citation: FLA. STATUTES 464-012.*

The ARNP dispensing practitioner must comply with all state and federal laws and regulations applicable to all dispensing practitioners under Section 465.0276, F.S.

*Citation: FLA. ADMIN. CODE ch. 64B9-4.011(2).*

**Georgia**

In addition to and without limiting the authority granted pursuant to Code Section 43-34-23, a
physician may delegate to an advanced practice registered nurse in accordance with a nurse protocol agreement the authority to order drugs, medical devices, medical treatments, diagnostic studies, or in life-threatening situations, radiographic imaging tests.

*Citation: GA. CODE ANN. § 43-34-25(b).*

“Nurse protocol agreement” means a written document mutually agreed upon and signed by an advanced practice registered nurse and a physician, by which document the physician delegates to that advanced practice registered nurse the authority to perform certain medical acts pursuant to this Code section, and which acts may include, without being limited to, the ordering of drugs, medical devices, medical treatments, diagnostic studies, or in life-threatening situations radiographic imaging tests. Such agreements shall conform to the provisions set forth in Subsection (c) of this Code section.

*Citation: GA. CODE ANN. § 43-34-25(a)(10).*

“Order” means to prescribe pursuant to a nurse protocol agreement which drug, medical device, medical treatment, diagnostic study, or in life-threatening situations, radiographic imaging test is
appropriate for a patient and to communicate the same in writing, orally, via facsimile, or electronically.

_Citation_: GA. CODE ANN. § 43-34-25(a)(11).

A written prescription drug order issued pursuant to this Code section shall be signed by the advanced practice registered nurse and shall be on a form which shall include, without limitation, the names of the advanced practice registered nurse and delegating physician who are parties to the nurse protocol agreement, the patient’s name and address, the drug or device ordered, directions with regard to the taking and dosage of the drug or use of the device, and the number of refills. . . .

_Citation_: GA. CODE ANN. § 43-34-25(d).

An advanced practice registered nurse may be authorized under a nurse protocol agreement to request, receive, and sign for professional samples and may distribute professional samples to patients. . . .

_Citation_: GA. CODE ANN. § 43-34-25(e).
No prescription drug orders submitted by an APRN for Schedule I or II controlled substances . . .

_Citation:_ GA. _RULES_ § 410-11.14(2)(e)1.

**Hawaii**

The board shall grant prescriptive authority to qualified advanced practice registered nurses and shall designate the requirements for advanced nursing practice related to prescriptive authority. The board shall determine the exclusionary formulary for qualified advanced practice registered nurses who are granted prescriptive authority.

_Citation:_ HAW. _STATUTES_ § 457-8.6(a).

Advanced practice registered nurses shall be considered qualified if they have met the requirements of section 457-8.5(a), and have met the advanced pharmacology requirements for initial prescriptive authority pursuant to rules adopted by the board. Only qualified advanced practice registered nurses authorized to diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources and, only as appropriate, to the practice specialty in which the advanced practice nurse is qualified, may:
1. Prescribe and administer over the counter drugs, legend drugs, and controlled substances pursuant to this chapter and to chapter 329 and request, receive, and dispense manufacturers’ prepackaged samples of over the counter drugs, and non-controlled legend drugs to patients under their care; provided that an advanced practice registered nurse shall not request, receive, or sign for professional controlled substance samples;

2. Prescribe, order, and dispense medical devices and equipment; and

3. Plan and initiate a therapeutic regimen that includes nutritional, diagnostic, and supportive services including home health care, hospice, and physical and occupational therapy.

*Citation: HAW. STATUTES § 457-8.6(c).*

a. The requirements for prescriptive authority are as follows:

1. A completed application for prescriptive authority for controlled or non-controlled substances provided by the board and submitted with all appropriate documents (unless
currently filed with the board) and required fees;

2. Proof of a current, unencumbered license as a registered nurse in this State and in all other states in which the nurse has a current and active license;

3. Proof of a current, unencumbered recognition or license as an advanced practice registered nurse in this State and in all other states in which the nurse has a current and active recognition or license as an advanced practice registered nurse or similar designation;

4. Proof of a current, unencumbered certification for specialized and advanced nursing practice from a national certifying body recognized by the board;

5. Proof of successful completion of an accredited graduate-level nursing program with a significant educational and practical concentration on the direct care of patients, recognized by the board, leading to a master’s degree as a certified registered nurse
anesthetist, a nurse midwife, a clinical nurse specialist, or a nurse practitioner;

6. Proof of successful completion of at least thirty contact hours, as part of a master’s degree program from an accredited, board-recognized college or university, of advanced pharmacology education, including advanced pharmacotherapeutics that is integrated into the curriculum, within the three-year time period immediately preceding the date of application. If completed more than the three-year time period, then one of the following shall be completed within the three-year time period immediately preceding the date of application for initial prescriptive authority:

   A. At least thirty contact hours of advanced pharmacology, including advanced pharmacotherapeutics, from an accredited, board-recognized college or university; or

   B. At least thirty contact hours of continuing education (“CE”) approved by board-recognized national certifying bodies in
advanced pharmacology, including advanced pharmacotherapeutics related to the applicant’s scope of nursing practice specialty; and

7. Payment of a non-refundable application fee.

b. APRNs authorized to prescribe non-controlled substances and who subsequently wish to prescribed controlled substances shall submit the appropriate application for prescriptive authority for controlled substances and meet the requirements of this chapter.

c. Upon satisfying all requirements in chapter 457, HRS, and this chapter, and payment of required fees, the board shall grant prescriptive authority to the APRN.

d. Nothing in this section shall preclude a registered nurse, a licensed practical nurse, or an APRN from carrying out the prescribed medical orders of a licensed dentist, physician, osteopath, or podiatrist license in accordance with chapters 448, 453, or 463E, HRS, or the orders of a recognized APRN granted prescriptive authority in accordance with this chapter.
The APRN shall comply with all applicable state and federal laws and rules relating to prescribing and administering of drugs. The APRN with prescriptive authority shall only prescribe, order, and dispense medical devices and equipment appropriate to the APRN’s specialty.

f. Prescriptions by an APRN with prescriptive authority shall be written in accordance with 16-95-82.

Prescriptive authority renewal for recognized advanced practice registered nurses.

a. Prescriptive authority for each APRN shall expire on June 30 of every odd-numbered year and shall be renewed biennially. APRNs seeking renewal of prescriptive authority shall also satisfy the renewal requirements for APRN recognition pursuant to section 16-89-87 and submit the following:

1. Evidence of current certification in the nursing practice specialty by a board-recognized national certifying body; and
2. Documentation of successful completion, during the prior biennium, of thirty contact hours of appropriate continuing education as determined by the board in the practice specialty area, eight contact hours of which shall be in pharmacology, including pharmacotherapeutics, related to the APRN’s clinical practice specialty area, approved by board-recognized national certifying bodies, the American Nurses Association, the American Medical Association, or accredited colleges or universities. Documentation of successful completion of continuing education required for recertification by a recognized national certifying body, earned within the current renewal biennium, may be accepted in lieu of the thirty hours of continuing education required for renewal.

b. Failure, neglect, or refusal to renew the prescriptive authority by a recognized APRN on or before June 30 of each odd-numbered year shall result in automatic forfeiture of prescriptive authority. Failure of the APRN to renew prescriptive authority shall cause the
APRN prescriptive authority to forfeit on the day after the expiration date. The APRN shall not prescribe until prescriptive authority has been restored. Renewal application deadlines shall be as established by the board. Prescriptive authority may be restored within six months from the date of forfeiture, provided the restoration application is in compliance with subsection (a) and is submitted with an additional payment of a restoration fee. Failure to restore within the time frame provided shall constitute an automatic termination of the prescriptive authority. Thereafter, to be eligible for prescriptive authority, the applicant shall meet the requirements of section 16-89-119.

c. Any APRN subject to this chapter who fails to renew his or her prescriptive authority and continues to practice as a recognized APRN with prescriptive authority shall be considered an illegal practitioner and shall be subject to penalties provided for by law.

*Citation: Hawk. Admin. R. § 16-89-123.*

**Idaho**

An advanced practice registered nurse is authorized to perform advanced nursing practice, which may
include the prescribing, administering and dispensing of therapeutic pharmacologic agents, as defined by board rules.

**Citation:** IDAHO CODE § 54-1402(1).

Prescriptive and Dispensing Authorization. Means the legal permission to prescribe, deliver, distribute and dispense pharmacologic and non-pharmacologic agents to a client in compliance with Board rules and applicable federal and state laws. Pharmacologic agents include legend and Schedule II through V controlled substances.

**Citation:** IDAHO ADMIN. CODE § 23.01.01.271.15.

An application for the authority to prescribe and dispense pharmacologic and non-pharmacologic agents may be made as part of initial licensure application or by separate application at a later date. Advanced practice registered nurses who complete their APRN graduate or post-graduate educational program after December 31, 2015, will automatically be granted prescriptive and dispensing authority with the issuance of their Idaho licensure.

a. An advanced practice professional nurse who applies for authorization to prescribe
pharmacologic and non-pharmacologic agents within the scope of practice for the advanced practice role, shall:

i. Be currently licensed as an advanced practice professional nurse in Idaho;

ii. Provide evidence of completion of thirty (30) contact hours of post-basic education in pharmacotherapeutics.

iii. Submit a completed, notarized application form provided by the Board; and

iv. Remit fees prescribed in Section 901 of these rules.

Citation: IDAHO ADMIN. CODE § 23.01.01.315.01(a).

Illinois

(Section scheduled to be repealed on January 1, 2018.)

a. A collaborating physician or podiatric physician may, but is not required to, delegate prescriptive authority to an advanced practice nurse as part of a written collaborative agreement. This authority may, but is not required to, include prescription of, selection of, orders for, administration of, storage of, acceptance of samples of, and
dispensing over the counter medications, legend drugs, medical gases, and controlled substances categorized as any Schedule III through V controlled substances, as defined in Article II of the Illinois Controlled Substances Act, and other preparations, including, but not limited to, botanical and herbal remedies. The collaborating physician or podiatric physician must have a valid current Illinois controlled substance license and federal registration to delegate authority to prescribe delegated controlled substances.

b. To prescribe controlled substances under this Section, an advanced practice nurse must obtain a mid-level practitioner controlled substance license. Medication orders shall be reviewed periodically by the collaborating physician or podiatric physician.

c. The collaborating physician or podiatric physician shall file with the Department notice of delegation of prescriptive authority and termination of such delegation, in accordance with rules of the Department. Upon receipt of this notice delegating authority to prescribe any Schedule III through V controlled substances, the licensed advanced practice nurse shall be eligible to register for a mid-level practitioner controlled substance license
under Section 303.05 of the Illinois Controlled Substances Act.

d. In addition to the requirements of Subsections (a), (b), and (c) of this Section, a collaborating physician or podiatric physician may, but is not required to, delegate authority to an advanced practice nurse to prescribe any Schedule II controlled substances, if all of the following conditions apply:

1. Specific Schedule II controlled substances by oral dosage or topical or transdermal application may be delegated, provided that the delegated Schedule II controlled substances are routinely prescribed by the collaborating physician or podiatric physician. This delegation must identify the specific Schedule II controlled substances by either brand name or generic name. Schedule II controlled substances to be delivered by injection or other route of administration may not be delegated.

2. Any delegation must be controlled substances that the collaborating physician or podiatric physician prescribes.
3. Any prescription must be limited to no more than a 30-day supply, with any continuation authorized only after prior approval of the collaborating physician or podiatric physician.

4. The advanced practice nurse must discuss the condition of any patients for whom a controlled substance is prescribed monthly with the delegating physician.

5. The advanced practice nurse meets the education requirements of Section 303.05 of the Illinois Controlled Substances Act.

e. Nothing in this Act shall be construed to limit the delegation of tasks or duties by a physician to a licensed practical nurse, a registered professional nurse, or other persons. Nothing in this Act shall be construed to limit the method of delegation that may be authorized by any means, including, but not limited to, oral, written, electronic, standing orders, protocols, guidelines, or verbal orders.

Citation: ILL. COMP. STAT. § 65/65-40. [Section scheduled to be repealed on JANUARY 1, 2018.]
a. A collaborating physician or podiatric physician who delegates prescriptive authority to an advanced practice nurse shall include that delegation in the written collaborative agreement. This authority may include prescription of, selection of, orders for, administration of, storage of, acceptance of samples of, and dispensing over the counter medications, legend drugs, medical gases, and controlled substances categorized as Schedule III through V controlled substances, as defined in Article II of the Illinois Controlled Substances Act, and other preparations, including, but not limited to, botanical and herbal remedies. The collaborating physician or podiatric physician must have a valid current Illinois controlled substance license and federal registration to delegate authority to prescribed delegated controlled substances.

b. Pursuant to Section 65-40(d) of the Act, a collaborating physician may, but is not required to, delegate authority to an advanced practice nurse to prescribe any Schedule II controlled substances by oral dosage or topical or transdermal application if all the following conditions apply:
1. The delegated Schedule II controlled substance is specifically identified by either brand name or generic name. For the purposes of this Section generic substitution pursuant to Section 25 of the Pharmacy Practice Act shall be allowed under this Section when not prohibited by a prescriber's indication on the prescription that the pharmacist “may not substitute.”

2. The delegated Schedule II controlled substances are routinely prescribed by the collaborating physician or podiatric physician.

3. Any prescription must be limited to no more than a 30-day supply, with any continuation authorized only after prior approval of the collaborating physician or podiatric physician.

4. The advanced practice nurse must discuss the condition of any patients for whom a controlled substance is prescribed monthly with the delegating physician or podiatric physician.

5. The advanced practice nurse meets the education requirements of Section 303.05 of the Illinois Controlled Substances Act [720 ILCS 570].
c. An APN who has been given controlled substances prescriptive authority shall be required to obtain an Illinois mid-level practitioner controlled substance license in accordance with 77 Ill. Adm. Code 3100. The physician or podiatric physician shall file a notice of delegation of prescriptive authority with the Division. The delegation of authority form shall be submitted to the Division prior to the issuance of a controlled substance license.

d. The APN may only prescribe and dispense controlled substances that the collaborating physician or podiatric physician prescribes. Licensed dentists may not delegate prescriptive authority.

e. All prescriptions written and signed by an advanced practice nurse shall indicate the name of the collaborating physician or podiatric physician. The collaborating physician’s or podiatric physician’s signature is not required. The APN shall sign his/her own name.

f. An APN may receive and dispense samples per the collaborative agreement.

g. Medication orders shall be reviewed periodically by the collaborating physician or podiatric physician.
Indiana
An advanced practice nurse may be authorized to prescribe legend drugs, including controlled substances, if the advanced practice nurse does the following:

1. Submits an application . . . with the required fee;
2. Submits proof of holding an active, unrestricted:
   A. Indiana registered nurse license; or
   B. registered nurse license in another compact state. . . .
3. Submits proof of having met the requirements of all applicable laws for practice as advanced practice nurse in the state of Indiana.
4. Submits proof of a baccalaureate or higher degree in nursing.
5. If the applicant holds a baccalaureate degree only, submits proof of certification as a nurse practitioner or certified nurse midwife by a national organization recognized by the board and which requires a national certifying examination.
6. Submits proof of having successfully completed a graduate level pharmacology course, consisting of at least two (2) semester hours of academic credit from a college or university accredited by the Commission on Recognition of Postsecondary Accreditation:
   A. within five (5) years of the date of application; or
   B. if the pharmacology course was completed more than five (5) years immediately preceding the date of the application, the applicant must submit proof of the following:
      i. Completing at least thirty (30) actual contact hours of continuing education during the two (2) years immediately preceding the date of application, including a minimum of at least eight (8) actual contact hours of pharmacology, all of which must be approved by a nationally approved sponsor of continuing education for nurses.
      ii. Prescriptive experience in another jurisdiction within the five (5) years immediately
preceding the date of application.

7. Submits proof of collaboration with a licensed practitioner in the form of a written practice agreement that sets forth the manner in which the advanced practice nurse and licensed practitioner will cooperate, coordinate, and consult with each other in the provision of health care to patients.

8. Written practice agreements for advanced practice nurses applying for prescriptive authority shall not be valid until prescriptive authority is granted by the board.

*Citation:* **IND. ADMIN. CODE** tit. 848, r. 5-1-1.

**Iowa**

“Prescriptive authority” is the authority granted to an ARNP registered in Iowa in a recognized nursing specialty to prescribe, deliver, distribute, or dispense prescription drugs, devices, and medical gases when the nurse is engaged in the practice of that nursing specialty. Registration as a practitioner with the Federal Drug Enforcement Administration and the Iowa board of pharmacy examiners extends this authority to controlled substances. ARNPs shall access the Iowa board of pharmacy examiners Web
site for Iowa pharmacy law and administrative rules and the Iowa Board of Pharmacy Examiners Newsletter.

Citation: Iowa Admin. Code r. 655-7.1(152).

Kansas
An advanced practice registered nurse may prescribe drugs pursuant to a written protocol as authorized by a responsible physician. Each written protocol shall contain a precise and detailed medical plan of care for each classification of disease or injury for which the advanced practice registered nurse is authorized to prescribe and shall specify all drugs which may be prescribed by the advanced practice registered nurse. Any written prescription order shall include the name, address, and telephone number of the responsible physician. The advanced practice registered nurse may not dispense drugs, but may request, receive, and sign for professional samples and may distribute professional samples to patients pursuant to a written protocol as authorized by a responsible physician. In order to prescribe controlled substances, the advanced practice registered nurse shall
1. register with the federal drug enforcement administration; and
2. notify the board of the name and address of the responsible physician or physicians. In no case shall the scope of authority of the advanced practice registered nurse exceed the normal and customary practice of the responsible physician. . . . For the purposes of this subsection, “responsible physician” means a person licensed to practice medicine and surgery in Kansas who has accepted responsibility for the protocol and the actions of the advanced registered nurse practitioner when prescribing drugs.

_Citation:_ KAN. STAT ANN. § 65-1130(d).

a. Each written protocol that an advanced practice registered nurse is to follow when prescribing, administering, or supplying a prescription-only drug shall meet the following requirements:

1. Specify for each classification of disease or injury the corresponding class of drugs that the advanced practice registered nurse is permitted to prescribe;
2. Be maintained in either a loose-leaf notebook or a book of published protocols. The notebook or book of published protocols shall include a cover page containing the following data:

   A. The names, telephone numbers, and signatures of the advanced practice registered nurse and a responsible physician who has authorized the protocol; and

   B. The date on which the protocol was adopted or last reviewed; and

3. Be kept at the advanced practice registered nurse’s principal place of practice.

   b. Each advanced practice registered nurse shall ensure that each protocol is reviewed by the advanced practice registered nurse and physician at least annually.

   c. Each prescription order in written form shall meet the following requirements:

      1. Include the name, address, and telephone number of the practice
location of the advanced practice registered nurse;

2. include the name, address, and telephone number of the responsible physician;

3. be signed by the advanced practice registered nurse with the letters A.P.R.N.;

4. be from a class of drugs prescribed pursuant to protocol; and

5. contain any D.E.A. registration number issued to the advanced practice registered nurse when a controlled substance, as defined in K.S.A. 65-4101(e) and amendments thereto, is prescribed.

d. Nothing in this regulation shall be construed to prohibit any registered nurse or licensed practical nurse or advanced practice registered nurse from conveying a prescription order orally or administering a drug if acting under the lawful direction of a person licensed to practice either medicine and surgery or dentistry, or licensed as an advanced practice registered nurse.

_Citation_: KAN. ADMIN. REGS. § 60-11-104a.
Kentucky

Advanced practice registered nursing shall include prescribing medications and ordering treatments, devices, and diagnostic tests, which are consistent with the scope and standard of practice of the advanced practice registered nurse.

_Citation:_ 201 KY. _ADMIN. REGS._ § 20:057 (Section 4).

KRS 314.011(8)(c) authorizes the Controlled Substances Formulary Development Committee to make recommendations to the Board of Nursing concerning any limitations for the prescription of specific controlled substances by advanced practice registered nurses. This administrative regulation establishes limitations for the prescription of specific controlled substances by advanced practice registered nurses.

Section 1. Specific Controlled Substances. The following controlled substances have been identified as having the greatest potential for abuse or diversion:

1. Diazepam (Valium), a Schedule IV medication;
2. Clonazepam (Klonopin), a Schedule IV medication;
3. Lorazepam (Ativan), a Schedule IV medication;
4. Alprazolam (Xanax), a Schedule IV medication; and
5. Carisoprodol (Soma), a Schedule IV medication.

Section 2. Limitations. Prescriptions for the medications listed in Section 1 of this administrative regulation shall be limited to a thirty (30) day supply without any refills.

Citation: 201 KY. ADMIN. REGS. § 20:059.

Louisiana
An APRN may be granted prescriptive authority to prescribe assessment studies, including pharmaceutical diagnostic testing (e.g., dobutamine stress testing), legend and certain controlled drugs, therapeutic regimens, medical devices and appliances, receiving and distributing a therapeutic regimen of prepackaged drugs prepared and labeled by a licensed pharmacist, and free samples supplied by a drug manufacturer, and distributing drugs for administration to and use by other individuals within the scope of practice as defined by the board in R.S. 37.913(3)(b).
Requirements for prescriptive privileges:

- Hold a current, unencumbered, unrestricted, and valid RN licensure
- Hold a current, unencumbered, unrestricted, and valid APRN licensure
- Evidence of 500 hours of clinical practice as a licensed APRN within 2 years prior to applying for prescriptive and distributing authority
- 45 hours of education in pharmacotherapeutics
- 45 contact hours of pathophysiology/physiology in formal educational program
- Collaborative practice agreement with one or more licensed collaborating physicians
- Each year . . . six hours of continuing education in pharmacotherapeutics

Citation: LA. ADMIN. CODE tit. 46, § XLVII.4513(D).

For additional details, read La. Admin. Code, tit. 46.

Maine

General regulations relating to prescriptive and dispensing authority:

- If the applicant has not prescribed drugs within the past 2 years, the applicant shall provide evidence of satisfactory completion of 15 contact
hours of pharmacology within the 2 years prior to applying for approval to practice.

- If the applicant has not prescribed drugs within the past 5 years, the applicant shall provide evidence of satisfactory completion of 45 contact hours (or 3 credits) of pharmacology within the 2 years prior to applying for approval to practice.

- A certified nurse practitioner or certified nurse-midwife who holds prescriptive authority in another U.S. jurisdiction must submit evidence of the following:
  1. Minimum of 200 hours of practice in an expanded specialty role within the preceding 2 years; and
  2. 45 contact hours (or 3 credits) of pharmacology equivalent to the requirements set forth in Section 6(3)(A) and (B).

- In addition to the required client and drug information, a written prescription shall include the date, printed name, legal signature, specialty category, business address, and telephone number of the prescribing certified nurse practitioner or certified nurse-midwife.

- Prescriptions may be written for medical appliances and devices and for over-the-counter drugs.
- Drugs in the formulary may be prescribed, administered, dispensed, or distributed in combination.
- Any product name drug may be prescribed, administered, dispensed, or distributed as long as the generic name or category for the drug is in the formulary.
- The certified nurse practitioner and certified nurse-midwife shall comply with all applicable laws and rules in prescribing, administering, dispensing, and distributing drugs, including compliance with the labeling requirements and all other applicable requirements of the Board of Commissioners of the Profession of Pharmacy.
- For the administration, dispensing, and distribution of controlled substances, the certified nurse practitioner and certified nurse-midwife shall comply with the requirements in the Code of Federal Regulations, 21 CFR Chapter II, Sections 1301, 1304.03 and 1304.04.
- Certified nurse practitioners or certified nurse-midwives may receive prepackaged complimentary samples of drugs included in the formulary for prescription writing and may distribute these samples to clients.
- Distribution of drug samples shall be in accordance with D.E.A. laws, regulations, and guidelines.
A. Certified nurse practitioners and certified nurse–midwives are authorized to prescribe the following:
   1. over the counter drugs
   2. appliances and devices
   3. drugs related to the specialty area of certification
   4. drugs prescribed off label according to common and established standards of practice.

B. Regardless of the schedules indicated on the certificate issued by the Drug Enforcement Administration, the certified nurse practitioner and certified nurse–midwife shall prescribe only those controlled drugs from Schedules II, III, IIIN, IV, and V. A Drug Enforcement Agency (D.E.A.) number is required to prescribe these Drugs.

Citation: Code Me.R. § 02 380 008 (Section 7).

Maryland

A nurse practitioner may independently perform the following functions:
A nurse practitioner may personally prepare and dispense any drug that a nurse practitioner is authorized to prescribe in the course of treating a patient at:

1. A medical facility or clinic that specializes in the treatment of medical cases reimbursable through workers’ compensation insurance;
2. A medical facility or clinic that is operated on a nonprofit basis;
3. A health center that operates on a campus of an institution of higher education;
4. A public health facility, a medical facility under contract with a State or local health department, or a facility funded with public funds; or
5. A nonprofit hospital or a nonprofit hospital out-patient facility as authorized under the policies established by the hospital.
B. A nurse practitioner who personally prepares and dispenses a drug in the course of treating a patient shall:
   1. Comply with the labeling requirements of Health Occupations Article, §12-505, Annotated Code of Maryland;
   2. Record the dispensing of the prescription drug on the patient’s chart;
   3. Allow the Division of Drug Control to enter and inspect the nurse practitioner’s office at all reasonable hours;
   4. Except for starter dosages or samples dispensed without charge, provide the patient with a written prescription; and
   5. Stamp all Schedule III, IV, and V prescriptions with the letter “C” in red ink, not less than 1 inch high in the lower right hand corner.

C. A nurse practitioner shall:
   1. Maintain two separate files, one for Schedule II prescriptions and another file for all other prescriptions; and
   2. Maintain all prescriptions for 5 years.

D. A nurse practitioner may personally prepare and dispense a starter dosage of any drug
the nurse practitioner is authorized to prescribe. The nurse practitioner shall:

1. Label the starter dosage in compliance with the labeling requirements of Health Occupations Article, §12-505, Annotated Code of Maryland;
2. Provide the starter dose free of charge; and
3. Enter the starter dose dispensed in the patient’s medical record.

_Citation:_ MD. REGS. CODE 10 § 27.07.07.

On April 26, 2016, the MD governor signed HB437 into law, which creates a prescription drug monitoring program (PDMP) in MD that includes mandatory registration for all CDS prescribers. See the Board of Nursing website for more information.

**Massachusetts**

A nurse practitioner or psychiatric nurse mental health clinical specialist may issue written prescriptions and order tests and therapeutics pursuant to guidelines mutually developed and agreed upon by the nurse and the supervising physician in accordance with regulations promulgated jointly by the board and the board of registration in medicine after consultation with the
board of registration in pharmacy. A prescription made by a nurse practitioner or psychiatric nurse mental health clinical specialist shall include the name of the physician with whom such nurse has developed and signed mutually agreed upon guidelines approved by said board and said board of registration in medicine pursuant to Section 80B.

_Citation:_ MASS. ANN. LAWS, ch. 112, § 80E.

. . . CNPs are authorized to issue written certifications of marijuana for medical use as provided pursuant to the mutually agreed upon guidelines between the NP and the physician supervising the CNP’s prescriptive practice.

_Citation:_ MASS. REGS. CODE tit. 244, § 4.06(3)(d).

Prior to prescribing a hydrocodone-only extended release medication that is not in an abuse deterrent form, an APRN engaged in prescriptive practice must:

a. Thoroughly assess the patient, including an evaluation of the patient’s risk factors, substance abuse history, presenting condition(s), current medication(s), a determination that other pain management
treatments are inadequate, and a check of the patient’s data through the online Prescription Monitoring Program;  
b. Discuss the risks and benefits of the medication with the patient;  
c. Enter into a Pain Management Treatment Agreement with the patient that shall appropriately address drug screening, pill counts, safe storage and disposal and other requirements based on the patient’s diagnoses, treatment plan, and risk assessment unless a Pain Management Treatment Agreement is not clinically indicated due to the severity of the patient’s medical condition;  
d. Supply a Letter of Medical Necessity as required by the Board of Registration in Pharmacy pursuant to 247 CMR 9.04(8)(c); and  
e. Document 244 CMR 4.28(a) through (d) in the patient’s medical record.

The purpose of 244 CMR 4.28 is to enhance the public health and welfare by promoting optimum therapeutic outcomes, avoiding patient injury and eliminating medication errors. Nothing in 244 CMR 4.28 shall alter the standard of care a licensee must
use when prescribing any Schedule II, III or IV controlled substance.

_Citation:_ MASS. REGS. CODE tit. 244, § 4.07(3).

4.

a. A supervising physician shall review and provide ongoing direction for the APN’s prescriptive practice in accordance with written guidelines mutually developed and agreed upon with the APN pursuant to M.G.L. c. 112, §§ 80B, 80C, 80E, 80G, 80H, and the regulations of the Board of Registration in Nursing (244 CMR) and 243 CMR 2.10. This supervision shall be provided as is necessary, taking into account the education, training and experience of the APN, the nature of the APN’s practice, and the physician’s availability to provide clinical backup to ensure that the APN is providing patient care in accordance with accepted standards of practice.

b. A supervising physician shall sign prescriptive practice guidelines only with those APNs for whom he or she is able to provide supervision consistent
with 243 CMR 2.10(2) and (3), taking into account factors including, but not limited to geographical proximity, practice setting, volume and complexity of the patient population, and the experience, training and availability of the supervising physician and the APN(s).

c. A supervising physician shall not enter into guidelines, pursuant to M.G.L.c. 112, §§ 80B, 80C, 80E, 80G, or 80H and 243 CMR 2.10, unless the APN has professional malpractice liability insurance as required by the BORN regulations.

5.

a. A physician who supervises an APN engaged in prescriptive practice shall do so in accordance with written guidelines mutually developed and agreed upon with the APN.

b. In all cases, the written guidelines shall:
   1. identify the supervising physician and APN;
   2. include a defined mechanism for the delegation of supervision to
another physician including, but not limited to, the duration and scope of the delegation;

3. describe the nature and scope of the APN’s prescribing practice;

4. identify the types of medication(s) to be prescribed, specify any limitations on medications to be prescribed, and describe the circumstances in which physician consultation or referral is required;

5. describe the use of established procedures for the treatment of common medical conditions which the nurse may encounter;

6. include provisions for managing emergencies;

7. include a defined mechanism and time frame to monitor prescribing practices;

8. include protocols for the initiation of intravenous therapies and Schedule II drugs;

9. specify that the initial prescription of Schedule II drugs must be reviewed within 96 hours;
10. specify that the guidelines must be kept on file in the workplace and be reviewed and re-executed every two years; and

11. conform to M.G.L. c. 94C, the regulations of the Department of Public Health at 105 CMR 700.000.

_Citation:_ MASS. REGS. CODE tit. 243, § 2.10 (4) and (5).


**Michigan**

A licensee who holds a license other than a health profession subfield license may delegate to a licensed or unlicensed individual who is otherwise qualified by education, training, or experience the performance of selected acts, tasks, or functions where the acts, tasks, or functions fall within the scope of practice of the licensee’s profession and will be performed under the licensee’s
supervision. A licensee shall not delegate an act, task, or function under this section if the act, task, or function, under standards of acceptable and prevailing practice, requires the level of education, skill, and judgment required of the licensee under this article.

Citation: MICH. COMP. LAWS § 333.16215(1).

Note: House Bill 5400, signed in January 2017, gave nurse practitioners the authority to prescribe nonscheduled drugs.

A supervising physician may delegate in writing to a registered professional nurse the ordering, receipt, and dispensing of complimentary starter dose drugs other than controlled substances as defined by article 7 or federal law. When the delegated ordering, receipt, or dispensing of complimentary starter dose drugs occurs, both the registered professional nurse’s name and the supervising physician’s name shall be used, recorded, or otherwise indicated in connection with each order, receipt, or dispensing.
1. A physician may delegate the prescription of controlled substances listed in schedules 3 to 5 to a registered nurse who holds specialty certification under section 17210 of the code, with the exception of a nurse anesthetist, if the delegating physician establishes a written authorization that contains all of the following information:
   a. The name, license number, and signature of the delegating physician.
   b. The name, license number, and signature of the nurse practitioner or nurse midwife.
   c. The limitations or exceptions to the delegation.
   d. The effective date of the delegation.

2. A delegating physician shall review and update a written authorization on an annual basis from the original date or the date of amendment, if amended. A delegating physician shall note the review date on the written authorization.

3. A delegating physician shall maintain a written authorization in each separate location
of the physician’s office where the delegation occurs.

4. A delegating physician shall ensure that an amendment to the written authorization is in compliance with subrule (1) (a) to (d) of this rule.

5. A delegating physician may delegate the prescription of schedule 2 controlled substances only if all of the following conditions are met:
   a. The delegating physician and nurse practitioner or nurse midwife are practicing within a health facility as defined in section 20106(d), (g), or (i) of the code; specifically, freestanding surgical outpatient facilities, hospitals, and hospices.
   b. The patient is located within the facility described in subdivision (a) of this subrule.
   c. The delegation is in compliance with this rule.

6. A delegating physician may not delegate the prescription of schedule 2 controlled substances issued for the discharge of a patient for a quantity for more than a 7-day period.
7. A delegating physician shall not delegate the prescription of a drug or device individually, in combination, or in succession for a woman known to be pregnant with the intention of causing either a miscarriage or fetal death.

_Citation:_ MICHIGAN BOARD OF MEDICINE RULES R338.2305.

**Minnesota**

Advanced practice registered nurses are authorized to:

1. diagnose, prescribe, and institute therapy or referrals of patients to health care agencies and providers;
2. prescribe, procure, sign for, record, administer, and dispense over-the-counter, legend, and controlled substances, including sample drugs; and
3. plan and initiate a therapeutic regimen that includes ordering and prescribing durable medical devices and equipment, nutrition, diagnostic services, and supportive services including, but not limited to, home health care, hospice, physical therapy, and occupational therapy.
a. Advanced practice registered nurses must:
   1. comply with federal Drug Enforcement Administration (DEA) requirements related to controlled substances; and
   2. file any and all of the nurse’s DEA registrations and numbers with the board.

Citation: Minn. Stat. Ann. § 148.235(7b)(a).

A licensed doctor of medicine, a doctor of osteopathy, duly licensed to practice medicine, a doctor of dental surgery, a doctor of dental medicine, a licensed doctor of podiatry, a licensed advanced practice registered nurse, or a licensed doctor of optometry limited to Schedules IV and V, and in the course of professional practice only, may prescribe, administer, and dispense a controlled substance included in Schedules II through V of section 152.02, may cause the same to be administered by a nurse, an intern or an assistant under the direction and supervision of the doctor, and may cause a person who is an appropriately certified and licensed health care professional to prescribe and administer the same within the
expressed legal scope of the person’s practice as defined in Minnesota Statutes.

Citation: Minn. Stat. § 152.12 (Subd. 1).

Mississippi
Certified nurse midwives and certified nurse practitioners may apply for controlled substance prescriptive authority after completing a board approved educational program. Certified nurse midwives and certified nurse practitioners who have completed the program and received prescription authority from the board may prescribe Schedules II–V. The words “administer,” “controlled substances,” and “ultimate user,” shall have the same meaning as set forth in Section 41-29-105, unless the context otherwise requires. The board shall promulgate rules governing prescribing of controlled substances, including distribution, record keeping, drug maintenance, labeling and distribution requirements and prescription guidelines for controlled substances and all medications. Prescribing any controlled substance in violation of the rules promulgated by the board shall constitute a violation of Section 73-15-29(1) (f), (k) and (l) and shall be grounds for disciplinary action. The prescribing, administering or distributing of any legend drug or other medication in violation of the
rules promulgated by the board shall constitute a violation of Section 73-15-29(1) (f), (k) and (l) and shall be grounds for disciplinary action.

*Citation: Miss. Nursing Practice Law § 73-15-20(8).*

**Missouri**

The methods of treatment and the authority to administer, dispense, or prescribe drugs delegated in a collaborative practice arrangement between a collaborating physician and collaborating APRN shall be within the scope of practice of each professional and shall be consistent with each professional’s skill, training, education, competence, licensure, and/or certification and shall not be further delegated to any person except that the individuals identified in sections 338.095 and 338.198, RSMo, may communicate prescription drug orders to a pharmacist.

*Citation: Mo. Code Regs. Ann. tit. 20, § 2200-4.200(3)(A).*

The collaborating physician shall consider the level of skill, education, training, and competence of the collaborating RN or APRN and ensure that the delegated responsibilities contained in the collaborative practice arrangement are consistent
with that level of skill, education, training, and competence.

*Citation: Mo. Code Regs. Ann. tit. 20, § 2200-4.200(3)(C).*

The methods of treatment, including any authority to administer, dispense, or prescribe drugs, delegated in a collaborative practice arrangement between a collaborating physician and a collaborating APRN shall be delivered only pursuant to a written agreement, jointly agreed-upon protocols, or standing orders that are specific to the clinical conditions treated by the collaborating physician and collaborating APRN.

*Citation: Mo. Code Regs. Ann. tit. 20, § 2200-4.200(3)(F).*

Methods of treatment delegated and authority to administer, dispense, or prescribe drugs shall be subject to the following:

1. The physician retains the responsibility for ensuring the appropriate administering, dispensing, prescribing, and control of drugs utilized pursuant to a collaborative practice
arrangement in accordance with all state and federal statutes, rules, or regulations;

2. All labeling requirements outlined in Section 338.059, RSMo shall be followed;

3. Consumer product safety laws and Class B container standards shall be followed when packaging drugs for distribution;

4. All drugs shall be stored according to the *United States Pharmacopeia* (USP) (2010), . . . recommended conditions, which is incorporated by reference. This does not include any later amendments or additions;

5. Outdated drugs shall be separated from the active inventory;

6. Retrievable dispensing logs shall be maintained for all prescription drugs dispensed and shall include all information required by state and federal statutes, rules, or regulations;

7. All prescriptions shall conform to all applicable state and federal statutes, rules, or regulations and shall include the name, address, and telephone number of the collaborating physician and collaborating APRN.

*Citation: MO. CODE REGS. ANN. tit. 20, § 2200-4.200((3)G).*
In addition to administering and dispensing controlled substances, an APRN, as defined in section 335.016, RSMo, may be delegated the authority to prescribe controlled substances listed in Schedules III, IV, and V of section 195.017, RSMo, in a written collaborative practice arrangement, except that, the collaborative practice arrangement shall not delegate the authority to administer any controlled substances listed in Schedules III, IV, and V of section 195.017, RSMo, for the purpose of inducing sedation or general anesthesia for therapeutic, diagnostic, or surgical procedures. Schedule III narcotic controlled substance prescriptions shall be limited to a one hundred twenty (120)-hour supply without refill.

*Citation: Mo. Code Regs. Ann. tit. 20, § 2200-4.200(3)(G)9.*

An APRN may not prescribe controlled substances for his or her own self or family. Family is defined as spouse, parents, grandparents, great-grandparents, children, grandchildren, great-grandchildren, brothers and sisters, aunts and uncles, nephews and nieces, mother-in-law, father-in-law, brothers-in-law, sisters-in-law, daughters-in-law, and sons-in-law. Adopted and step members are also included in family.
An APRN or RN in a collaborative practice arrangement may only dispense starter doses of medication to cover a period of time for seventy-two (72) hours or less with the exception of Title X family planning providers or publicly funded clinics in community health settings that dispense medications free of charge.

Montana
Application for Prescriptive Authority

1. The APRN seeking prescriptive authority shall submit a completed application and the appropriate fee for prescriptive authority as specified in ARM 24.159.401.

2. The APRN seeking prescriptive authority who has graduated from an accredited program in the last five years shall submit:
   a. evidence of successful completion of a graduate level course of three semester credits in advanced pharmacology that includes instruction
in pharmacodynamics, pharmacokinetics, and pharmacotherapeutics of all broad categories of agents;

b. evidence of successful completion of a graduate level course that includes differential diagnosis/disease management; and

c. evidence of supervised clinical practice that integrates pharmacologic intervention with patient management.

3. The APRN seeking prescriptive authority who has graduated more than five years ago from an accredited program must complete either a graduate level course of three semester credits or 45 contact hours of continuing education that includes instruction in pharmacodynamics, pharmacokinetics, and pharmacotherapeutics of all broad categories of agents.

4. The APRN with prescriptive authority from another board jurisdiction shall submit a completed application and the appropriate fees for prescriptive authority as specified in ARM 24.159.401. The application must include evidence of a current unencumbered
APRN license with prescriptive authority in another board jurisdiction.

*Citation:* Mont. Admin. R. § 24.159.1463.

**Prescribing Practices**

1. Prescriptions must comply with all applicable state and federal laws.

2. All written prescriptions must include the following information:
   a. name, title, address, and phone number of the APRN who is prescribing;
   b. name of client;
   c. date of prescription;
   d. the full name of the drug, dosage, route, amount to be dispensed, and directions for its use;
   e. number of refills;
   f. signature of the prescriber on written prescriptions; and
   g. Drug Enforcement Administration (DEA) number of the prescriber on all scheduled drugs;

3. Records of all prescriptions must be documented in client records.
4. An APRN with prescriptive authority shall comply with federal DEA requirements for controlled substances.

5. An APRN with prescriptive authority may not prescribe controlled substances for self or members of the APRN’s immediate family.

6. In an emergency situation, Schedule II drugs may be phoned in to the pharmacist pursuant to 21 CFR 1306.11(d).

7. An APRN with prescriptive authority may not delegate the prescribing or dispensing of drugs to any other person.

_Citation:_ MONT. ADMIN. R. § 24-159.1464.

**Nebraska**

2. Nurse practitioner practice means health promotion, health supervision, illness prevention and diagnosis, treatment, and management of common health problems and acute and chronic conditions, including:
   a. Assessing patients, ordering diagnostic tests and therapeutic treatments, synthesizing and analyzing data, and applying advanced nursing principles;
   b. Dispensing, incident to practice only, sample medications which are provided
by the manufacturer and are provided at no charge to the patient; and

c. Prescribing therapeutic measures and medications relating to health conditions within the scope of practice.


**Nevada**

1. An applicant for a license to practice as an advanced practice registered nurse will be authorized to issue written prescriptions for controlled substances, poisons, dangerous drugs and devices only if the applicant:
   a. Is authorized to do so by the Board;
   b. Submits an application for authority to issue written prescriptions for controlled substances, poisons, dangerous drugs or devices to the Board; and
   c. Has successfully completed:
      1. A program that complies with the requirements set forth in paragraph (a) of subsection 1 of NAC 632.260 and includes an advanced course in pharmacotherapeutics; or
2. A program of academic study that:
   i. Is approved by the Board;
   ii. Consists of at least 2 semester credits or an equivalent number of quarter credits in advanced pharmacotherapeutics; and
   iii. Is completed within the 2 years immediately preceding the date the application is submitted to the Board.

2. In addition to the information contained in the application for a license to practice as an advanced practice registered nurse, an applicant who completes, before June 1, 2005, a program designed to prepare an advanced practice registered nurse and who does not hold a master’s or doctorate degree with a major in nursing must, in his or her application for authority to write a prescription for controlled substances, poisons, dangerous drugs and devices, include documentation of 1,000 hours of active
practice prescribing medication in the immediately preceding 2 years as an advanced practice registered nurse.

3. Except as otherwise provided in subsection 4, if an advanced practice registered nurse who is authorized to prescribe certain controlled substances, poisons, dangerous drugs and devices changes his or her role or population of focus, he or she must submit an application to the Board for authority to prescribe those controlled substances, poisons, dangerous drugs and devices which are currently within the standard of practice in that role or population of focus. In addition to the information contained in an application submitted pursuant to this subsection, an advanced practice registered nurse who completes, before June 1, 2005, a program designed to prepare an advanced practice registered nurse and who does not hold a master’s or doctorate degree with a major in nursing must include in his or her application documentation of 1,000 hours of active practice prescribing medication in the new role or population of focus as an advanced practice registered nurse.

4. An advanced practice registered nurse who:
a. Is authorized to prescribe certain controlled substances, poisons, dangerous drugs and devices; and
b. Changes his or her role or population of focus to a role or population of focus that is substantially similar to his or her former role or population of focus, is not required to submit to the Board the application required pursuant to subsection 3 if the Board has authorized him or her to prescribe controlled substances, poisons, dangerous drugs and devices in the practice of his or her former role or population of focus.

_Citation:_ NEV. ADMIN. CODE § 632.257.

An advanced practice registered nurse may only prescribe controlled substances, poisons, dangerous drugs or devices which are currently within the standard of practice in his or her identified role or population focus.

_Citation:_ NEV. ADMIN. CODE § 632.259.

The State Board of Nursing will issue a certificate to dispense controlled substances, poisons,
dangerous drugs and devices to an advanced practice registered nurse if the advanced practice registered practitioner:

a. Successfully completes an examination administered by the State Board of Nursing on Nevada law relating to pharmacy; and

b. Submits to the State Board of Nursing his or her affidavit verifying that he or she has made application with the State Board of Pharmacy for a certificate of registration.

*Citation: NEV. ADMIN. CODE § 632.2595(1).*

**New Hampshire**

An APRN shall have plenary authority to possess, compound, prescribe, administer, and dispense and distribute controlled and non-controlled drugs within the scope of the APRN’s practice as defined by this chapter. Such authority may be denied, suspended, or revoked by the board after notice and the opportunity for hearing, upon proof that the authority has been abused.

*Citation: N.H. REV. STAT. ANN. § 326-B:11.III.*

**New Jersey**
a. In addition to all other tasks which a registered professional nurse may, by law, perform, an advanced practice nurse may manage preventive care services, and diagnose and manage deviations from wellness and long-term illnesses, consistent with the needs of the patient and within the scope of practice of the advanced practice nurse, by:

1. initiating laboratory and other diagnostic tests;
2. prescribing or ordering medications and devices, as authorized by subsections b. and c. of this section; and
3. prescribing or ordering treatments, including referrals to other licensed healthcare professionals, and performing specific procedures in accordance with the provisions of this subsection.

b. An advanced practice nurse may order medications and devices in the inpatient setting, subject to the following conditions:

1. the collaborating physician and advanced practice nurse shall address in the joint protocols whether prior
consultation with the collaborating physician is required to initiate an order for a controlled dangerous substance;

2. the order is written in accordance with standing orders or joint protocols developed in agreement between a collaborating physician and the advanced practice nurse, or pursuant to the specific direction of a physician;

3. the advanced practice nurse authorizes the order by signing the nurse’s own name, printing the name and certification number, and printing the collaborating physician’s name;

4. the physician is present or readily available through electronic communications;

5. the charts and records of the patients treated by the advanced practice nurse are reviewed by the collaborating physician and the advanced practice nurse within the period of time specified by rule adopted by the Commissioner of Health pursuant to Section 13 of P.L.1991, c.377 (C.45:11–52);

6. the joint protocols developed by the collaborating physician and the
advanced practice nurse are reviewed, updated, and signed at least annually by both parties; and

7. the advanced practice nurse has completed six contact hours of continuing professional education in pharmacology related to controlled substances, including pharmacologic therapy and addiction prevention and management, in accordance with regulations adopted by the New Jersey Board of Nursing. The six contact hours shall be in addition to New Jersey Board of Nursing pharmacology education requirements for advanced practice nurses related to initial certification and recertification of an advanced practice nurse as set forth in N.J.A.C. 13:37-7.2.

c. An advanced practice nurse may prescribe medications and devices in all other medically appropriate settings, subject to the following conditions:

1. the collaborating physician and advanced practice nurse shall address in the joint protocols whether prior consultation with the collaborating
physician is required to initiate a prescription for a controlled dangerous substance;

2. the prescription is written in accordance with standing orders or joint protocols developed in agreement between a collaborating physician and the advanced practice nurse, or pursuant to the specific direction of a physician;

3. the advanced practice nurse writes the prescription on a New Jersey Prescription Blank pursuant to P.L.2003, c.280 (C.45:14-40 et seq.), signs the nurse’s own name to the prescription and prints the nurse’s name and certification number;

4. the prescription is dated and includes the name of the patient and the name, address, and telephone number of the collaborating physician;

5. the physician is present or readily available through electronic communications;

6. the charts and records of the patients treated by the advanced practice nurse are periodically reviewed by the
collaborating physician and the advanced practice nurse;

7. the joint protocols developed by the collaborating physician and the advanced practice nurse are reviewed, updated, and signed at least annually by both parties; and

8. the advanced practice nurse has completed six contact hours of continuing professional education in pharmacology related to controlled substances, including pharmacologic therapy and addiction prevention and management, in accordance with regulations adopted by the New Jersey Board of Nursing. The six contact hours shall be in addition to New Jersey Board of Nursing pharmacology education requirements for advanced practice nurses related to initial certification and recertification of an advanced practice nurse as set forth in N.J.A.C. 13:37-7.2.

d. The joint protocols employed pursuant to Subsections b. and c. of this section shall conform with standards adopted by the Director of the Division of Consumer Affairs
pursuant to Section 12 of P.L.1991, c.377 (C.45:11–51) or Section 10 or P.L.1999, c.85 (C.45-49.2), as applicable.

Citation: N.J. STAT. ANN. § 45:11-49.

a. An advanced practice nurse may prescribe or order medications and devices and shall do so in conformity with the provisions of this subchapter, N.J.S.A. 45:11-45 et seq., and written protocols for the prescription of medications and devices jointly developed by the advanced practice nurse and the collaborating physician in accordance with the standards of N.J.S.A. 45:11-51 and N.J.A.C. 13:37-6.3.

b. An advanced practice nurse may prescribe or order treatments, including referrals, and shall do so in conformity with the provisions of this subchapter and N.J.S.A. 45:11-45 et seq.

c. An advanced practice nurse who issues prescriptions in any setting other than in a licensed acute care or long-term care facility may issue written prescriptions for medications to patients only on New Jersey Prescription Blanks in accordance with N.J.S.A. 45:14-55.
d. An advanced practice nurse shall include the following information on each prescription blank issued:

1. The prescribing advanced practice nurse’s full name, designation, that is, APN, address, telephone number, and certification number.
2. The full name, date of birth and address of the patient;
3. The date of issuance;
4. The name, strength, route and quantity of the medication prescribed;
5. The number of refills permitted or time limit for refills, or both;
6. A handwritten, original signature;
7. An explicit indication, by initials placed next to “do not substitute,” if a specified brand name drug is to be dispensed;
8. The full name, title, address, telephone number, and license number of the collaborating physician
9. Words, in addition to numbers, to indicate the drug quantity authorized if the prescription is for a controlled dangerous substance, for example: “ten (10) Percodan” or “five (5) Ritalin 5 mg”; and
10. If the prescription is for a controlled
dangerous substance, the advanced
practice nurse’s DEA number and
instructions as to the frequency of use.

_Citation:_ N.J. _Admin. Code_ tit. 13, § 37-7.9.

**New Mexico**
Certified nurse practitioners may . . . practice
independently and make decisions regarding health
care needs of the individual, family, or community
and carry out health regimens, including the
prescription and distribution of dangerous drugs and
controlled substances included in Schedules II
through V of the Controlled Substances Act. . . .

_Citation:_ N.M. _Stat. Ann._ § 61-3-23.2.B(2).

Certified nurse practitioners who have fulfilled
requirements for prescriptive authority may
prescribe in accordance with the rules, regulations,
guidelines, and formularies for individual certified
nurse practitioners promulgated by the board.

_Citation:_ N.M. _Stat. Ann._ § 61-3-23.2.C.

Certified nurse practitioners who have fulfilled
requirements for prescriptive authority may
distribute to their patients dangerous drugs and controlled substances included in Schedules II through V of the Controlled Substances Act that have been prepared, packaged or fabricated by a registered pharmacist or doses of drugs that have been prepackaged by a pharmaceutical manufacturer in accordance with the Pharmacy Act and the New Mexico Drug, Device and Cosmetic Act.

_Citation: N.M. STAT. ANN. § 61-3-23.2.D._

**New York**
Prescriptions for drugs, devices, and immunizing agents may be issued by a nurse practitioner . . . in accordance with the practice agreement and practice protocols except as permitted by paragraph (b) of this subdivision. The nurse practitioner shall obtain a certificate from the department upon successfully completing a program including an appropriate pharmacology component, or its equivalent, as established by the commissioner’s regulations, prior to prescribing under this paragraph. The certificate issued under Section 6910 shall state whether the nurse practitioner has successfully completed such a program or equivalent and is authorized to prescribe under this paragraph.
An NP must obtain a DEA number in order to prescribe or dispense controlled substances.

Citation: NEW YORK STATE NURSING BOARD OFFICE, PRACTICE

Information: Prescription Privileges, August 2016.

North Carolina
b. Prescribing and dispensing stipulations are as follows:

1. Drugs and devices that may be prescribed by the nurse practitioner in each practice site shall be included in the collaborative practice agreement as outlined in Rule.0810(b) of this Section.

2. Controlled Substances (Schedules II, IIN, III, IIIN, IV, V) defined by the State and Federal Controlled Substances Acts may be procured, prescribed or ordered as established in the collaborative practice agreement, providing all of the following requirements are met:
A. The nurse practitioner has an assigned DEA number which is entered on each prescription for a controlled substance;

B. Dosage units for Schedules II, IIN, III, and IIIN are limited to a 30 day supply; and

C. The supervising physician(s) must possess the same schedule(s) of controlled substances as the nurse practitioner’s DEA registration. [Additional conditions omitted.]

_Citation:_ N.C. ADMIN. CODE tit. 21, r. 36.0809.

**North Dakota**

Requirements for prescriptive authority.

Applicants for prescriptive authority shall:

1. Be currently licensed as an advanced practice registered nurse in North Dakota.
2. Submit a complete, notarized prescriptive authority application and pay the fee of fifty dollars.
3. Submit a completed transcript with degree posted from an accredited graduate level advanced practice registered nurse program and which includes evidence of completion of advanced pharmacotherapy, physical assessment, and pathophysiology.

4. Provide evidence of completion of thirty contact hours of education or equivalent in pharmacotherapy related to the applicant’s scope of advanced practice that:
   a. Have been obtained within a three-year period of time immediately prior to the date of application for prescriptive authority; or
   b. May otherwise be approved by the board.

*Citation: N.D. Admin. Code § 54-05-03.1-09.*

The advanced practice registered nurse plans and initiates a therapeutic regimen that includes ordering and prescribing medical devices and equipment, nutrition, diagnostic and supportive services including home health care, hospice, and physical and occupational therapy.

1. A permanent advanced practice registered nurse license with the addition of prescriptive
authority shall be issued upon meeting all requirements.

2. The advanced practice registered nurse with prescriptive authority may prescribe drugs as defined by chapter 43-15-01 pursuant to applicable state and federal laws.

3. A prescriptive authority advanced practice registered nurse license does not include drug enforcement administration authority for prescribing controlled substances. Each licensee must apply for and receive a drug enforcement administration number before writing prescriptions for scheduled drugs.

4. The licensee may prescribe, administer, sign for, dispense over-the-counter, legend, and controlled substances, and procure pharmaceuticals, including samples following state and federal regulations.

5. The signature on documents related to prescriptive practices must clearly indicate that the licensee is an advanced practice registered nurse.

6. The advanced practice registered nurse with prescriptive authority may not prescribe, sell, administer, distribute, or give to oneself or to one’s spouse or child any drug legally classified as a controlled substance or
recognized as an addictive or dangerous drug.

7. Notwithstanding any other provision, a practitioner who diagnoses a sexually transmitted disease, such as chlamydia, gonorrhea, or any other sexually transmitted infection, in an individual patient may prescribe or dispense, and a pharmacist may dispense, prescription antibiotic drugs to that patient’s sexual partner or partners, without there having been an examination of that patient’s sexual partner or partners.

_Citation:_ N.D. _ADMIN. CODE_ § 54-05-03.1-10.

**Ohio**

Under a certificate to prescribe issued under Section 4723.48 of the Revised Code, a . . . certified nurse practitioner is subject to all of the following:

A. A . . . certified nurse practitioner shall not prescribe any drug or therapeutic device that is not included in the types of drugs and devices listed on the formulary established in rules adopted under Section 4723.50 of the Revised Code;

B. The prescriptive authority of a . . . certified nurse practitioner shall not exceed the
prescriptive authority of the collaborating physician or podiatrist. . . ;

C.

1. Except as provided in division (C)(2) or (3) of this section, . . . a certified nurse practitioner may prescribe to a patient a Schedule II controlled substance only if all of the following are the case:
   a. The Patient has a terminal condition, as defined in section 2133.01 of the Revised Code.
   b. The collaborating physician of the . . . certified nurse practitioner initially prescribed the substance for the patient.
   c. The prescription is for an amount that does not exceed the amount necessary for the patient’s use in a single, twenty-four-hour period.

[Sections omitted.]

E. A . . . certified nurse practitioner may personally furnish to a patient a sample of any drug or therapeutic device included in the types of drugs and devices listed in the formulary. . . . [conditions apply].

Citation: OHIO REV. CODE ANN. § 4723.481.
Oklahoma
A Certified Nurse Practitioner shall be eligible, in accordance with the scope of practice of the Certified Nurse Practitioner, to obtain recognition as authorized by the Board to prescribe, as defined by rules promulgated by the Board pursuant to this section and subject to the medical direction of a supervising physician. This authorization shall not include dispensing drugs, but shall not preclude, subject to federal regulations, the receipt of, the signing for, or the dispensing of professional samples to patients.

Citation: OKLA. STAT. ANN. tit. 59, § 567.3a.(6).

a. The Advanced Practice Registered Nurse may prescribe in writing, orally, or by other means of telecommunication, drugs or medical supplies which are not listed on the exclusionary formulary approved by the Board, and which are within the scope of practice for the Advanced Practice Registered Nurse, and that are not otherwise prohibited by law.

b. The Advanced Practice Registered Nurse must have a supervising physician on file with the Board prior to prescribing drugs or medical supplies.
c. The Advanced Practice Registered Nurse with prescriptive authority who prescribes Schedule III-V drugs will comply with state and Federal Drug Enforcement Administration (DEA) requirements prior to prescribing controlled substances.

No more than a 30-day supply for Schedule III-V drugs shall be prescribed by the Advanced Practice Registered Nurse with prescriptive authority.

_Citation:_ OKLA. ADMIN. CODE § 485:10-16-5.

The Advanced Practice Registered Nurse applicant for prescriptive authority shall:

1. hold current Registered Nurse and Certified Nurse Practitioner, Certified Nurse Midwife, or Clinical Nurse Specialist licenses in Oklahoma;
2. submit a completed application for each type of recognition and advanced practice specialty certification held containing such information as the Board may prescribe and the required fee. If the application is not completed within one (1) year, a new application and new fee will be required;
3. submit a written statement from an Oklahoma-licensed physician supervising prescriptive authority which identifies a mechanism for:

   A. appropriate referral, consultation, and collaboration between the Advanced Practice Registered Nurse and physician supervising prescriptive authority;

   B. availability of communication between the Advanced Practice Registered Nurse and physician supervising prescriptive authority through direct contact, telecommunications, or other appropriate electronic means for consultation, assistance with medical emergencies or patient referral;

4. submit documentation verifying completion of forty-five contact hours of Category B continuing education or three academic credit hours of education, as required by law and defined in the rules and regulations, in a course or courses in pharmacotherapeutic management that target/s Advanced Practice Registered Nurses or individuals enrolled in an advanced practice registered nursing education program and/or other authorized
prescribers. Such contact hours or academic credits shall be obtained within a time period of three (3) years immediately preceding the date of receipt of application for prescriptive authority. The three (3) year time period may be waived if the applicant has graduated from their advanced practice registered nursing education program within a time period of three years immediately preceding the date of application for prescriptive authority and evidence that didactic and clinical preparation for prescribing was incorporated throughout the program;

5. Submit documentation verifying successful completion of a graduate level advanced practice registered nursing education program that included an academic course in pharmacotherapeutic management and didactic and clinical preparation for prescribing incorporated throughout the program. Until January 1, 2016, a Clinical Nurse Specialist who verifies completion of a graduate level advanced practice registered nursing education program that included an academic course in pharmacotherapeutic management may meet the requirements in 485:10-16-4 in lieu of submitting verification of didactic and clinical preparation for
prescribing incorporated throughout the advanced practice nursing education program.

*Citation: OKLA. ADMIN. CODE § 485:10-16-3.*

**Oregon**

The Oregon State Board of Nursing may authorize a certified nurse practitioner or certified clinical nurse specialist to write prescriptions, including prescriptions for controlled substances listed in schedules II, III, IIIN, IV, and V.

*Citation: OR. REV. STAT. § 678.390(1).*

The nurse practitioner is independently responsible and accountable for the continuous and comprehensive management of a broad range of health care, which may include:

. . . Prescribing, dispensing, and administration of therapeutic devices and measures, including legend drugs and controlled substances as provided in Division 56 of the Oregon Nurse Practice Act, consistent with the definition of the practitioner’s specialty category and scope of practice.

*Citation: OR. ADMIN. R. § 851-050-0005(5)(l).*
1. A written prescription shall include the date, printed name, legal signature, specialty category/title, business address, and telephone number of the prescribing APRN, in addition to the required patient and drug information.

2. An electronically transmitted prescription as defined in OAR 855-006-0015 of the Pharmacy Act shall include the name and immediate contact information of the prescriber and be electronically encrypted or in some manner protected by up-to-date technology from unauthorized access, alteration, or use. Controlled substances have additional restrictions as defined by the DEA, which shall be followed.

3. A tamper resistant prescription shall meet criteria as defined in OAR 855-006-0015 of the Pharmacy Act.

4. Prescriptions may be written for over the counter drugs, durable medical equipment (DME), and devices.

5. Prescriptions shall be signed by the prescriber with the abbreviated specialty title of the nurse practitioner, the title CRNA, or the title CNS.

6. The APRN shall comply with all applicable laws and rules in prescribing, administering,
and distributing drugs, including compliance with the labeling requirements of ORS Chapter 689.

7. An APRN shall only prescribe controlled substances in conjunction with their own valid and current DEA registration number appropriate to the classification level of the controlled substance.

8. Clinical nurse specialists and nurse practitioners with prescriptive authority are authorized to prescribe legend and controlled substances in Schedule II-V. Additionally, they may prescribe:
   a. Over-the-counter drugs;
   b. Appliances and devices;
   c. Orphan drugs;
   d. Limited access drugs;
   e. Antibiotics to partner(s) of patients diagnosed with a sexually transmitted infection without first examining the partner of the patient, consistent with Department of Human Services guidelines regarding Expedited Partner Therapy; and
   f. Off label.

*Citation:* OR. ADMIN. R. § 851-056-0010.
Additional requirements can be found at Or. Admin. R. 851-056-0004, 0006, 0018, and 0026.

Evaluation of appropriate prescribing by the Board is constructed based on the following premises:

1. APRNs may prescribe the drugs appropriate for patients within their scope of practice as defined by OAR 851-050-0005; or OAR 851-054-0020 and 0021; and OAR 851-052-0010.
2. APRNs shall be held independently accountable for their prescribing decisions;
3. All drugs prescribed shall have Food and Drug Administration (FDA) approval unless mentioned as an exception in OAR 851-056-0010.

*Citation: OR. ADMIN. R. § 851-056-0012.*

**Pennsylvania**

Collaborative Agreement—the written and signed agreement between a CRNP and a collaborating physician in which they agree to the details of their collaboration including the elements in the definition of collaboration.

*Citation: 49 PA. CODE § 21.251.*
A CRNP with prescriptive authority may, when acting in collaboration with a physician as set forth in a prescriptive authority collaborative agreement and within the CRNP’s specialty, prescribe and dispense drugs and give written or oral orders for drugs and other medical therapeutic or corrective measures.

*Citation:* 49 Pa. Code § 21.283(a).

b. A CRNP with current prescriptive authority approval from the Board may prescribe, dispense, and administer drugs and therapeutic or corrective measures consistent with the prescriptive authority collaborative agreement and relevant to the CRNP’s specialty from the following categories:

1. Antihistamines.

2. Anti-infective agents.

3. Antineoplastic agents, unclassified therapeutic agents, devices, and pharmaceutical aids.

4. Autonomic drugs.

5. Blood formation, coagulation and anticoagulation drugs, and thrombolytic and antithrombolytic agents.
6. Cardiovascular drugs.

7. Central nervous system agents.

8. Contraceptives including foams and devices.


10. Disinfectants for agents used on objects other than skin.


12. Enzymes.


15. Local anesthetics.

16. Eye, ear, nose, and throat preparations.

17. Serums, toxoids, and vaccines.

18. Skin and mucous membrane agents.


20. Vitamins.

c. A CRNP may not prescribe or dispense a drug from the following categories:

1. Gold compounds.
2. Heavy metal antagonists.
3. Radioactive agents.
4. Oxytocics.
5. Schedule I controlled substances as defined by Section 4 of the Controlled Substance, Drug, Device, and Cosmetic Act (35 P.S. § 780-104).

d. Restrictions on CRNP prescribing and dispensing practices are as follows:

1. A CRNP may write a prescription for a Schedule II controlled substance for up to a 30-day supply as identified in the collaborative agreement.
2. A CRNP may prescribe a Schedule III or IV controlled substance for up to a 90-day supply as identified in the collaborative agreement.

e. A CRNP may not delegate prescriptive authority.
A CRNP authorized to prescribe or dispense, or both, controlled substances shall register with the Drug Enforcement Administration.

Rhode Island

a. The board of nursing shall grant prescribing, ordering, dispensing and furnishing authority.

b. An APRN licensed by the board of nursing may prescribe, order, procure, administer, dispense and furnish over the counter, legend and controlled substances pursuant to applicable state and federal laws, when the APRN has completed an educational program as described in this chapter that includes courses in pathophysiology, pharmacology and physical assessment and is within the APRN’s role and population focus.

c. Prescribing, ordering, dispensing and furnishing shall include the authority to:
   1. Diagnose, prescribe and institute therapy or referrals of patients to health care agencies, health care providers and community resources;
2. Prescribe, procure, administer, dispense and furnish pharmacological agents, including over the counter, legend and controlled substances; and

3. Plan and initiate a therapeutic regimen that includes ordering and prescribing non-pharmacological interventions, including, but not limited to, durable medical equipment, medical devices, nutrition, blood and blood products, and diagnostic and supportive services including, but not limited to, home health care, hospice, and physical and occupational therapy.

d. Prescriptive privileges for the certified nurse practitioner shall include all the authority under the APRN license including:

1. Prescription of legend medications and prescription of controlled substances from schedules II, III, IV and V that are established in regulation; and

2. May be certified to prescribe controlled substances from Schedule I.

*Citation: R.I. GEN. LAWS § 5-34-49(a)–(d).*

**South Carolina**
D.

1. Delegated medical acts performed by a nurse practitioner, certified nurse–midwife, or clinical nurse specialist must be performed pursuant to an approved written protocol between the nurse and the physician . . . and must include, but is not limited to:

   b. this information for delegated medical acts:

   i. the medical conditions for which therapies may be initiated, continued, or modified;

   ii. the treatments that may be initiated, continued, or modified;

   iii. the drug therapies that may be prescribed;

   iv. situations that require direct evaluation by or referral to the physician.

E.
A. An NP, CNM, or CNS who applies for prescriptive authority:

a. must be licensed by the board as a nurse practitioner, certified nurse–midwife, or clinical nurse specialist;

b. shall submit a completed application on a form provided by the board;

c. shall submit the required fee;

d. shall provide evidence of completion of forty-five contact hours of education in pharmacotherapeutics acceptable to the board, within two years before application or shall provide evidence of prescriptive authority in another state meeting twenty hours in pharmacotherapeutics acceptable to the board, within two years before application;

e. shall provide at least fifteen hours of education in controlled substances acceptable to the board as part of the twenty hours
required for prescriptive authority if the NP, CNM, or CNS has equivalent controlled substance prescribing authority in another state;

f. shall provide at least fifteen hours of education in controlled substances acceptable to the board as part of the forty-five contact hours required for prescriptive authority if the NP, CNM, or CNS initially is applying to prescribe in Schedules III through V controlled substances.

B. The board shall issue an identification number to the NP, CNM, or CNS authorized to prescribe medications. Authorization for prescriptive authority is valid for two years unless terminated by the Board for cause. Initial authorization expires concurrent with the expiration of the Advanced Practice Registered Nurse license.

C. Authorization for prescriptive authority must be renewed after the applicant meets requirements for renewal and
provides documentation of twenty hours acceptable to the board of continuing education contact hours every two years in pharmacotherapeutics. For an NP, CNM, or CNS with controlled substance prescriptive authority, two of the twenty hours must be related to prescribing controlled substances.

F.

A. Authorized prescriptions by a nurse practitioner, certified nurse–midwife, or clinical nurse specialist with prescriptive authority:

   a. must comply with all applicable state and federal laws;

   b. is limited to drugs and devices utilized to treat common well-defined medical problems within the specialty field of the nurse practitioner or clinical nurse specialist, as authorized by the physician and listed in the approved written protocols. The Board of Nursing, Board of Medical Examiners, and Board
of Pharmacy jointly shall establish a listing of classifications of drugs that may be authorized by physicians and listed in approved written protocols;

c. do not include prescriptions for Schedule II controlled substances; however, Schedules III through V controlled substances may be prescribed if listed in the approved written protocol and as authorized by Section 44-53-300;

d. must be signed by the NP, CNM, or CNS with the prescriber’s identification number assigned by the board and all prescribing numbers required by law. The prescription form must include the name, address, and phone number of the NP, CNM, or CNS and physician and must comply with the provisions of Section 39-24-40. A prescription must designate a specific number of
refills and may not include a nonspecific refill indication;

e. must be documented in the patient record of the practice and must be available for review and audit purposes.

B. An NP, CNM, or CNS who holds prescriptive authority may request, receive, and sign for professional samples, except for controlled substances in Schedule II, and may distribute professional samples to patients as listed in the approved written protocol, subject to federal and state regulations.

*Citation:* S.C. Code Ann. § 40-33-34(D)–(F).

**South Dakota**
A nurse practitioner may perform the following overlapping scope of advanced practice nursing and medical functions pursuant to § 36-9A-15, including:

... The prescription of medications and provision of drug samples or a limited supply of labeled medications, including controlled drugs or substances listed on Schedule II in Chapter 34-20B
for one period of not more than thirty days, for treatment of causative factors and symptoms. Medications or sample drugs provided to patients shall be accompanied with written administration instructions and appropriate documentation shall be entered in the patient’s medical record.

_Citation:_ S.D. _Codified Laws_ § 36-9A-12(2).

**Tennessee**

The nurse practitioner who holds a certificate of fitness shall be authorized to prescribe and/or issue controlled substances listed in Schedules II, III, IV, and V of title 39, chapter 17, part 4, upon joint adoption of physician supervisory rules concerning controlled substances pursuant to Subsection (d).

_Citation:_ Tenn. _Code Ann._ § 63-7-123(b)(2)(A).

Any prescription written and signed or drug issued by a nurse practitioner under the supervision and control of a supervising physician shall be deemed to be that of the nurse practitioner. Every prescription issued by a nurse practitioner pursuant to this section shall be entered in the medical records of the patient and shall be written on a preprinted prescription pad bearing the name, address, and telephone number of the supervising
physician and of the nurse practitioner, and the nurse practitioner shall sign each prescription so written. Where the preprinted prescription pad contains the names of more than one (1) physician, the nurse practitioner shall indicate on the prescription which of those physicians is the nurse practitioner’s primary supervising physician by placing a checkmark beside or a circle around the name of that physician.

_Citation: Tennesse Code Annotated_ § 63-7-123(b)(3)(A).

The Nurse Practice Act T.C.A. § 63-7-101 et seq. requires a certification process for a nurse practitioner to prescribe and/or issue legend drugs.

_Citation: Tennessee Code, Rules and Regulations_ ch. 1000-4-.01(3).

Those applicants intending to prescribe, issue or administer controlled substances . . . shall maintain their Drug Enforcement Administration Certificate to Prescribe Controlled Substances at their practice location . . .

_Citation: Tennessee Code, Rules and Regulations_ ch. 1000-4-.04(3).

Texas
An APRN who has been issued full licensure and a valid prescription authorization number by the Board may order or prescribe non-prescription drugs, dangerous drugs, and devices, including durable medical equipment, in accordance with the standards and requirements set forth in this chapter. However, if the APRN wishes to also order or prescribe controlled substances, the APRN must also meet the additional requirements of §222.8 (relating to Authority to Order and Prescribe Controlled Substances) of this chapter.

Citation: Texas Rule tit. 22, § 222.7.

a. APRNs with full licensure and a valid prescription authorization number are eligible to obtain authority to order and prescribe certain categories of controlled substances. The APRN must comply with all federal and state laws and regulations relating to the ordering and prescribing of controlled substances in Texas, including but not limited to, requirements set forth by the Texas Department of Public Safety and the United States Drug Enforcement Administration.

b. Orders and prescriptions for controlled substances in Schedules III through V may be
authorized, provided the following criteria are met:

1. Prescriptions for a controlled substance in Schedules III through V, including a refill of the prescription, shall not exceed a 90 day supply. This requirement includes a prescription, either in the form of a new prescription or in the form of a refill, for the same controlled substance that a patient has been previously issued within the time period described by this subsection.

2. Beyond the initial 90 days, the refill of a prescription for a controlled substance in Schedules III through V shall not be authorized prior to consultation with the delegating physician and notation of the consultation in the patient’s chart.

3. A prescription of a controlled substance in Schedules III through V shall not be authorized for a child less than two years of age prior to consultation with the delegating physician and notation of the consultation in the patient’s chart.

c. Orders and prescriptions for controlled substances in Schedule II may be authorized
only:

1. in a hospital facility-based practice, in accordance with policies approved by the hospital’s medical staff or a committee of the hospital’s medical staff as provided by the hospital’s bylaws to ensure patient safety and as part of care provided to a patient who:
   A. has been admitted to the hospital for an intended length of stay of 24 hours or greater; or
   B. is receiving services in the emergency department of the hospital; or

2. as part of the plan of care for the treatment of a person who has executed a written certification of a terminal illness, has elected to receive hospice care, and is receiving hospice treatment from a qualified hospice provider.

Citation: TEXAS RULE tit. 22, § 222.8.

a. The prescriptive authority agreement is a mechanism by which an APRN is delegated
the authority to order or prescribe drugs or devices by a physician.

b. An APRN with full licensure and a valid prescriptive authorization number and a physician are eligible to enter into or be parties to a prescriptive authority agreement only if the APRN:

1. holds an active license to practice in this state that is in good standing. For purposes of this chapter, an APRN is in good standing if the APRN’s license and prescriptive authorization number are not encumbered by a disciplinary action;
2. is not currently prohibited by the Board from executing a prescriptive authority agreement; and
3. before executing the prescriptive authority agreement, the APRN and the physician disclose to the other prospective party to the agreement any prior disciplinary action by the applicable licensing board.

c. A prescriptive authority agreement must, at a minimum:

1. be in writing and signed and dated by the parties to the agreement;
2. state the name, address, and all professional license numbers of the parties to the agreement;
3. state the nature of the practice, practice locations, or practice settings;
4. identify either:
   A. the types or categories of drugs or devices that may be ordered or prescribed; or
   B. the types of categories of drugs or devices that may not be ordered or prescribed;
5. provide a general plan for addressing consultation and referral;
6. provide a plan for addressing patient emergencies;
7. state the general process for communication and the sharing of information between the APRN and the physician related to the care and treatment of patients;
8. if alternate physician supervision is to be utilized, designate one or more alternate physicians who may:
   A. provide appropriate supervision on a temporary basis in accordance with the
requirements established by the prescriptive authority agreement and the requirements of Chapter 157, Subchapter B, Occupations Code; and

B. participate in the prescriptive authority quality assurance and improvement plan meetings required under §157.0512, Occupations Code;

9. describe a prescriptive authority quality assurance and improvement plan and specify methods for documenting the implementation of the plan that includes the following:

   A. chart review, with the number of charts to be reviewed determined by the APRN and physician; and
   B. periodic face to face meetings between the APRN and the physician at a location agreed upon by both providers.

   d. The periodic face to face meetings described by subsection (c)(9)(B) of this section must:
      1. include:
A. the sharing of information relating to patient treatment and care, needed changes in patient care plans, and issues relating to referrals; and
B. discussion of patient care improvement; and

2. be documented and occur:
   A. except as provided by subparagraph (B) of this paragraph:
      i. at least monthly until the third anniversary of the date the agreement is executed; and
      ii. at least quarterly after the third anniversary of the date the agreement is executed, with monthly meetings held between the quarterly meetings by means of a remote electronic communications system, including video conferencing technology or the internet; or
B. if during the seven years preceding the date the agreement is executed, the APRN for at least five years was in a practice that included the exercise of prescriptive authority with required physician supervision:

i. at least monthly until the first anniversary of the date the agreement is executed; and

ii. at least quarterly after the first anniversary of the date the agreement is executed, with monthly meetings held between the quarterly meetings by means of a remote electronic communications system, including video conferencing technology or the internet.

e. Although a prescriptive authority agreement must include the information specified by this section, the agreement may include other provisions agreed to by the APRN and
physician, including provisions that were previously contained in protocols or other written authorization.

f. The APRN shall participate in quality assurance meetings with an alternate physician if the alternate physician has been designated in the prescriptive authority agreement to conduct and document the meeting.

g. The prescriptive authority agreement is not required to describe the exact steps that an APRN must take with respect to each specific condition, disease, or symptom.

h. An APRN who is a party to a prescriptive authority agreement must retain a copy of the agreement until the second anniversary of the date the agreement is terminated.

i. A party to the prescriptive authority agreement may not by contract waive, void, or nullify any provision of this rule or §157.0512 or §157.0513, Occupations Code.

j. In the event that a party to a prescriptive authority agreement is notified that the individual has become the subject of an investigation by the respective licensing board, the individual shall immediately notify the other party to the prescriptive authority agreement.
k. The prescriptive authority agreement and any amendments must be reviewed at least annually, dated, and signed by the parties to the agreement. The prescriptive authority agreement shall be made available to the Board, the Texas Medical Board, or the Texas Physician Assistant Board not later than the third business day after the date of receipt of the request from the respective licensing board.

l. The prescriptive authority agreement should promote the exercise of professional judgment by the APRN commensurate with the APRN’s education and experience and the relationship between the APRN and the physician.

m. The calculation under Chapter 157, Occupations Code, of the amount of time an APRN has practiced under the delegated prescriptive authority of a physician under a prescriptive authority agreement shall include the amount of time the APRN practiced under the delegated prescriptive authority of that physician before November 1, 2013.

_Citation_: _Texas Rule_ tit. 22, § 222.5.

Utah
“Practice of advanced practice registered nursing” means . . . Prescription or administration of prescription drugs or devices, including:

i. Local anesthesia;
ii. Schedule III-V controlled substances; and
iii. Schedule II controlled substances in accordance with Section 58-31b-803.

Citation: UTAH CODE ANN. § 58-31b-102(14)(c).

2. Except as provided in Subsection (3), an advanced practice registered nurse shall prescribe or administer a Schedule II controlled substance in accordance with a consultation and referral plan.

3. Except as provided by Subsection 58-31b-502(18), an advanced practice registered nurse may prescribe or administer a Schedule II controlled substance without a consultation and referral plan if the advanced practice registered nurse:
   a. has the lesser of:
      i. two years of licensure as a nurse practicing advanced practice registered nursing; or
      ii. 2,000 hours of experience practicing advanced practice
registered nursing;

b. prior to the first time prescribing or administering a Schedule III controlled substance for chronic pain, or a Schedule II controlled substance to a particular patient, unless treating the patient in a licensed general acute hospital, checks information about the patient in the Controlled Substance Database created in Section 58-37f-201; and

ii. periodically, thereafter, checks information about the patient in the Controlled Substance Database created in Section 58-37f-201; and

c. follows the health care provider prescribing guidelines for the treatment of an injured worker, developed by the Labor Commission under Title 34A, Chapter 2, Workers’ Compensation Act, or Title 34A, Chapter 3, Utah Occupational Disease Act, if:
i. the patient is an injured worker; and

ii. the Schedule II or III controlled substance is prescribed for chronic pain.

_Citation:_ UTAH CODE ANN. § 58-31b-803(2) and (3).

**Vermont**

“Advanced practice registered nurse” or “APRN” means a licensed registered nurse authorized to practice in this State who, because of specialized education and experience, is licensed and authorized to perform acts of medical diagnosis and to prescribe medical, therapeutic, or corrective measures under administrative rules adopted by the board.

_Citation:_ VT. STAT ANN. tit. 26, § 1572(4).

**Virginia**

In accordance with the provisions of this section and pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.), a licensed nurse practitioner, other than a certified registered nurse anesthetist, shall have the authority to prescribe Schedule II through Schedule VI controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.). Nurse
practitioners shall have such prescriptive authority upon the provision to the Board of Medicine and the Board of Nursing of such evidence as they may jointly require that the nurse practitioner has entered into and is, at the time of writing a prescription, a party to a written or electronic practice agreement with a patient care team physician that clearly states the prescriptive practices of the nurse practitioner. Such written or electronic practice agreements shall include the controlled substances the nurse practitioner is or is not authorized to prescribe and may restrict such prescriptive authority as described in the practice agreement. . . .

_Citation:_ VA. CODE ANN. § 54.1-2957.01.A.

The following restrictions shall apply to any nurse practitioner authorized to prescribe drugs and devices pursuant to this section:

1. The nurse practitioner shall disclose to the patient at the initial encounter that he is a licensed nurse practitioner. Any member of a patient care team shall disclose, upon request of a patient or his legal representative, the name of the patient care team physician and information regarding how to contact the patient care team physician.
2. Physicians shall not serve as a patient care team physician on a patient care team at any one time to more than six nurse practitioners.

*Citation: VA. CODE ANN. § 54.1-2957.01.E.*

A. A nurse practitioner with prescriptive authority may prescribe only within the scope of the written or electronic practice agreement with a patient care team physician.

B. At any time there are changes in the patient care team physician, authorization to prescribe, or scope of practice, the nurse practitioner shall revise the practice agreement and maintain the revised agreement.

C. The practice agreement shall contain the following:

1. A description of the prescriptive authority of the nurse practitioner within the scope allowed by law and the practice of the nurse practitioner.

2. An authorization for categories of drugs and devices within the requirements of § 54.1-2957.01 of the Code of Virginia.

3. The signature of the patient care team physician who is practicing with the nurse practitioner or a clear statement
of the name of the patient care team physician who has entered into the practice agreement.

_Citation:_ 17 VA. ADMIN. CODE § 90-40-90.

**Washington**

An advanced registered nurse practitioner under his or her license may perform for compensation nursing care, as that term is usually understood, of the ill, injured, or infirm and in the course thereof, she or he may do the following things that shall not be done by a person not so licensed, except as provided in RCW 18.79.260 and 18.79.270:

1. Perform specialized and advanced levels of nursing as recognized jointly by the medical and nursing professions, as defined by the commission;
2.Prescribe legend drugs and Schedule V controlled substances, as defined in the Uniform Controlled Substances Act, Chapter 69.50 RCW, and Schedules II through IV subject to RCW 18.79.240(1)(r) or (s) within the scope of practice defined by the commission;
3. Perform all acts provided in RCW 18.79.260;
4. Hold herself or himself out to the public or designate herself or himself as an advanced registered nurse practitioner or as a nurse practitioner.

*Citation:* WASH. REV. CODE § 18.79.250.

An ARNP may not . . . prescribe controlled substances in Schedule I.

An ARNP with prescriptive authority who prescribes controlled substances must be registered with the drug enforcement administration.

*Citation:* WASH. ADMIN. CODE § 246-840-420(2) and (3).

1. An ARNP licensed under chapter 18.79. RCW when authorized by the nursing commission may prescribe drugs and medical devices pursuant to applicable state and federal laws.

2. The ARNP when exercising prescriptive authority is accountable for competency in:
   a. Problem identification through appropriate assessment;
   b. Medication or device selection;
c. Patient education for use of therapeutics;
d. Knowledge of interactions of therapeutics;
e. Evaluation of outcome; and
f. Recognition and management of side effects, adverse reactions, and complications.

Citation: WASH. ADMIN. CODE § 246-840-400.

West Virginia
a. The board may, in its discretion, authorize an advanced practice registered nurse to prescribe prescription drugs in accordance with applicable state and federal laws.
b. The board shall propose legislative rules for legislative approval . . . governing the eligibility and extent to which an advanced practice registered nurse may prescribe drugs. The rules shall permit the prescribing of any drug, subject to the following exceptions and limitations:
   1. Except as provided in subdivision (3) of this subsection, an advanced practice registered nurse may not prescribe more than a seventy-two hour supply of any drug listed, or a drug containing
any substance listed, in Schedule II of the Uniform Controlled Substance Act, to any individual and the prescription may not be refillable;

2. An advanced practice registered nurse may prescribe up to a thirty-day supply of any drug listed, or drug containing any substance listed, in Schedule III of the Uniform Controlled Substance Act to any individual and the prescription may not be refillable; and

3. An advanced practice registered nurse may prescribe to any individual, for the treatment of Attention Deficit Disorder, up to a thirty-day supply of any controlled substance approved by the U.S. Food and Drug Administration for the treatment of this disorder and the prescription may not be refillable.

_Citation:_ W. Va. _Code Annotated_ § 30-7-15a(a) and (b).

3.1. The board shall grant prescriptive authority to an advanced practice registered nurse applicant who meets all eligibility requirements specified in W. Va. Code §30-7-15b and the following:
3.1.a. Prior to application to the board for approval for limited prescriptive authority, the applicant shall:

3.1.a.1. Successfully complete an advanced pharmacotherapy graduate level course approved by the board of not less than 45 pharmacology contact hours;

3.1.a.2. Provide documentation of the use of pharmacotherapy in clinical practice in the education program;

3.1.a.3. Provide evidence of 15 pharmacology contact hours in advanced pharmacotherapy completed within 2 years prior to application for prescriptive authority;

3.1.a.4. Submit official transcripts or certificates documenting completion of pharmacology and pharmacotherapy course work.

3.1.a.5. The board may request course outlines and/or descriptions of courses if
necessary to evaluate the pharmacology course content and objectives.

3.1.b. The advanced practice registered nurse shall submit a notarized application for prescriptive authority on forms provided by the Board with the following:

3.1.b.1. A fee set forth in the board’s Fees rule, 19CSR12.

3.1.b.2. When required, written verification of an agreement to a collaborative relationship with a licensed physician holding an unencumbered West Virginia license for prescriptive practice on forms provided by the board. The applicant shall certify on this form that the collaborative agreement includes the following:

3.1.b.2.A. Mutually agreed upon written guidelines or protocols for prescriptive authority as it applies to the advanced practice
registered nurse’s clinical practice;

3.1.b.2.B. Statements describing the individual and shared responsibilities of the advanced practice registered nurse and the physician pursuant to the collaborative agreement between them;

3.1.b.2.C. A provision for the periodic and joint evaluation of the prescriptive practice; and

3.1.b.2.D. A provision for the periodic and joint review and updating of the written guidelines or protocols.

3.1.b.2.E. Additional documentation at the request of the board.

3.1.b.3 The Advanced Practice Registered Nurse may have
limited prescriptive authority without a collaborative agreement after meeting the following outlined requirements:

3.1.b.3. (a) Have practiced at least three years in a duly-documented collaborative relationship with granted prescriptive authority;

3.1.b.3. (b) Be licensed in good standing with the board;

3.1.b.3. (c) Submit a completed application on forms developed by the board and pay an application fee.

3.1.b.4 The Board will identify and maintain data designating those Advanced Practice Registered Nurses approved to prescribe without a collaborative agreement.
3.2. If the board obtains information that an applicant for prescriptive authority was previously addicted to or dependent upon alcohol or the use of controlled substances, the board may grant prescriptive authority with any limitations it considers proper. The limitations may include, but are not limited to, restricting the types of schedule drugs a nurse may prescribe.

3.3. The board shall forward a copy of the verified collaborative agreement specified in Subdivision 3.1.b.2. of this rule to the Board of Medicine or to the Board of Osteopathy, whichever is indicated.

3.4. Upon satisfactory evidence that the advanced practice registered nurse applicant has met all above requirements for prescriptive authority, the Board shall assign an identification number to that nurse.

3.5. The board shall notify the Board of Pharmacy of those advanced practice registered nurses who have been granted prescriptive authority, and shall also provide the prescriber’s identification number and effective date of prescriptive authority.
3.6. The advanced practice registered nurse shall file with the board any restrictions on prescriptive authority that are not imposed by W. Va. Code §60A-3-301 et seq., or this rule, but which are within the written collaborative agreement and the name of the collaborating physician for each advanced practice registered nurse on the approved list.

3.7. The advanced practice registered nurse with prescriptive authority who wishes to prescribe Schedules III through V drugs shall comply with federal Drug Enforcement Agency requirements prior to prescribing controlled substances.

3.8. The advanced practice registered nurse shall immediately file any and all of his or her Drug Enforcement Agency registrations and numbers with the board.

3.9. The board shall maintain a current record of all advanced practice registered nurses with Drug Enforcement Agency registrations and numbers.

3.10. Any information filed with the board under the provisions of this rule shall be available, upon request, to any pharmacist, regulatory agency or board or shall be made
available pursuant to other state or federal law.

3.11. The APRN shall maintain with the board a current mailing and, if available, a current e-mail address.

...

5.1. The advanced practice registered nurse shall not prescribe from the following categories of drugs:

   5.1.a. Schedules I and II of the Uniform Controlled Substances Act;

   5.1.b. Antineoplastics;

   5.1.c. Radio-pharmaceuticals; or

   5.1.d. General anesthetics.

5.2. Drugs listed under Schedule III are limited to a 30 day supply without refill.

5.3. Each prescription and subsequent refills given by the advanced practice registered nurse shall be entered on the patient’s chart.

5.4. An advanced practice registered nurse may administer local anesthetics.
5.5. The advanced practice registered nurse who has been approved for limited prescriptive authority by the board may sign for, accept, and provide to patients samples of drugs received from a drug company representative.

5.6. The prescription authorized by an advanced practice registered nurse shall comply with all applicable standards of care related to prescribing, state and federal laws and regulations; must be signed by the prescriber with the legal designation or the designated certification title of the prescriber and must include the prescriber’s identification number assigned by the board or the prescriber’s National Provider Identifier (NPI) assigned by the National Plan and Provider Enumeration System pursuant to 45 CFR §162.408.

5.6.a. All prescriptions shall include the following information:

5.6.a.1. The name, title, address and phone number of the prescribing advanced practice registered nurse;
5.6.a.2. The name and date of birth of the patient;

5.6.a.3. The date of the prescription;

5.6.a.4. The full name of the drug, the dosage, the route of administration and directions for its use;

5.6.a.5. The number of refills;

5.6.a.6. The Drug Enforcement Agency number of the prescriber, when required by federal laws; and

5.6.a.7. The prescriptive authority identification number issued by the board or the prescriber’s National Provider Identifier (NPI) assigned by the National Plan and Provider Enumeration System pursuant to 45 CFR §162.408.

5.6.b. An advanced practice registered nurse shall at the time of the initial prescription record in the patient record the plan for continued evaluation of the
effectiveness of the controlled substances prescribed.

_Citation:_ W. Va. Code St. R. tit. 19, § 19-8-3 and 19-8-5.

**Wisconsin**

The board shall grant a certificate to issue prescription orders to an advanced practice nurse who meets the education, training, and examination requirements established by the board for a certificate to issue prescription orders. . . .

_Citation:_ Wis. Stat. § 441.16(2).

1. Advanced practice nurse prescribers shall communicate with patients through the use of modern communication techniques.

2. Advanced practice nurse prescribers shall facilitate collaboration with other healthcare professionals, at least 1 of whom shall be a physician, through the use of modern communication techniques.

3. Advanced practice nurse prescribers shall facilitate referral of patient health care records to other health care professionals and shall notify patients of their right to have their
health care records referred to other health care professionals.

4. Advanced practice nurse prescribers shall provide a summary of a patient’s health care records, including diagnosis, surgeries, allergies, and current medications to other health care providers as a means of facilitation case management and improved collaboration.

*Citation:* WIS. ADMIN. CODE § N8.10(1), (2), (3), and (4).

The advanced practice nurse prescriber:

1. May issue only those prescription orders appropriate to the advanced practice nurse prescriber’s areas of competence, as established by his or her education, training or experience.

2. May not issue a prescription order for any schedule I controlled substance.

3. May not prescribe, dispense or administer any amphetamine, sympathomimetic amine drug or compound designated as a schedule II controlled substance pursuant to the provisions of s. 961.16(5), Stats., to or for any person except for any of the following:
a. Use as an adjunct to opioid analgesic compounds for the treatment of cancer-related pain.
b. Treatment of narcolepsy.
c. Treatment of hyperkinesis.
d. Treatment of drug-induced brain dysfunction.
e. Treatment of epilepsy.
f. Treatment of depression shown to be refractory to other therapeutic modalities.

4. May not prescribe, order, dispense or administer any anabolic steroid for the purpose of enhancing athletic performance or for other nonmedical purpose.

5. Shall, in prescribing or ordering a drug for administration by a registered nurse or licensed practical nurse under s. 441.16 (3) (cm), Stats., present evidence to the nurse and to the administration of the facility where the prescription or order is to be carried out that the advanced practice nurse prescriber is properly certified to issue prescription orders.

Citation: WIS. ADMIN CODE § N 8.06.
1. Advanced practice nurse prescribers who prescribe independently shall maintain in effect malpractice insurance evidenced by one of the following:
   a. Personal liability coverage in the amounts specified in s. 655.23(4), Stats.
   b. Coverage under a group liability policy providing individual coverage for the nurse in the amounts set forth in s. 655.23(4), Stats. An advanced practice nurse prescriber covered under one or more such group policies shall certify on forms provided by the board that the nurse will independently prescribe only within the limits of the policy’s coverage, or shall obtain personal liability coverage for independent prescribing outside the scope of the group liability policy or policies.

2. Notwithstanding sub. (1), an advanced practice nurse prescriber who practices as an employee of this state or a governmental subdivision, as defined under s. 180.0103, Stats., is not required to maintain in effect malpractice insurance coverage, but the
nurse shall certify on forms provided by the board that the nurse will prescribe within employment policies.

3. An advanced practice nurse prescriber who prescribes under the supervision and delegation of a physician or CRNA shall certify on forms provided by the board that the nurse complies with s. N 6.03 (2) and (3), regarding delegated acts.

4. An advanced practice nurse prescriber who prescribes in more than one setting or capacity shall comply with the provisions of subs. (1), (2) and (3) applicable to each setting or capacity. An advanced practice nurse prescriber who is not an employee of this state or a governmental subdivision, and who prescribes independently in some situations and prescribes under the supervision and delegation of a physician or CRNA in other situations, shall meet the requirements of sub. (1) with respect to independent prescribing and the requirements of sub. (3) with respect to delegated prescribing.

5. Every advanced practice nurse who is certified to issue prescription orders shall annually submit to the board satisfactory
evidence that he or she has in effect malpractice insurance required by sub. (1).

_Citation: WIS. ADMIN CODE § N 8.08._

1. Except as provided in sub. (2), advanced practice nurse prescribers shall restrict their dispensing of prescription drugs to complimentary samples dispensed in original containers or packaging supplied by a pharmaceutical manufacturer or distributor.

2. An advanced practice nurse prescriber may dispense drugs to a patient if the treatment facility at which the patient is treated is located at least 30 miles from the nearest pharmacy.

_Citation: WIS. ADMIN CODE § N 8.09._

1. Advanced practice nurse prescribers shall communicate with patients through the use of modern communication techniques.

2. Advanced practice nurse prescribers shall facilitate collaboration with other health care professionals, at least 1 of whom shall be a physician, through the use of modern communication techniques.
**Wyoming**

“Advanced practice registered nurse (APRN)” means a nurse who:

May prescribe, administer, dispense, or provide nonprescriptive and prescriptive medications including prepackaged medications, except Schedule I drugs as defined in W.S. 35-7-1013 and 35-7-1014.

*Citation: WYO. STAT. ANN. § 33-21-120(a)(i).*

The Board may authorize an APRN to prescribe medications and devices, within the recognized scope of APRN’s role and population focus, and in accordance with all applicable state and federal laws including, but not limited to the Wyoming Pharmacy Act, the Wyoming Controlled Substances Act, the Federal Controlled Substances Act, their applicable Rules and Regulations.

*Citation: WYO. BOARD of NURSING RULES, ch. 3, § Section 2(b)(i).*
Chapter 6: Hospital Privileges

Until about 10 years ago, it was a tradition in the medical field for patients to be admitted to hospitals by their primary physicians, who then visited the patients in the hospitals and coordinated their care. Recently, that traditional model has been challenged by the realization that it is highly inefficient. More and more, “hospitalists,” that is, physicians and nurse practitioners (NPs) who specialize in the care of hospitalized patients, are taking over this aspect of practice.

Hospital privileges were so termed because hospitals traditionally “awarded” the status of admitting physician to community physicians who had gone through a hospital’s screening process. The screening process, administered by the physicians who already had privileges, was partly focused on credentialing and partly focused on keeping competing specialists out.
With the number of hospital days per hospital stay declining, some hospitals have become interested in broadening their market. While hospitals still want to be sure that the providers ordering hospital care are competent and adequately credentialed, a hospital that wants to maximize its business will also want to maximize the number of providers who can bring in patients. Therefore, hospitals are becoming more open to giving NPs admitting privileges.

**Are Hospital Privileges an Issue for NPs?**

NPs can practice without hospital privileges as long as they arrange for patients who need hospitalization to be covered by a provider with hospital privileges or a hospitalist. Nevertheless, if a health plan requires that its providers have hospital privileges, NPs will need hospital privileges.

Physicians, when arguing to health plans that only physicians should be primary care providers (PCPs) or specialist providers, have used hospital privileges as a way to distinguish themselves from NPs. NPs, they argue, do not have admitting privileges and therefore should not be PCPs. This leaves two important points unsaid. First, many NPs do have admitting privileges. Second, many PCPs no longer pursue hospital practice and hospital privileges.
because of the inefficiencies of having to be in two places—office and hospital—at once.

Do PCPs Need Hospital Privileges?
A patient in need of hospitalization who is being cared for by an NP or a physician can be accommodated in several ways. One approach is for the PCP who has hospital privileges to admit patients and continue to manage their care during hospitalization. The PCP coordinates specialty consultation, writes admission and discharge orders, takes calls from hospital nurses about the patient’s progress, and evaluates the patient on-site once or twice a day, or more as needed.

A second possible approach is for a PCP to turn the care of patients in need of hospitalization over to a physician (or NP) who has admitting privileges and who does hospital-based care and to have patients admitted under the physician’s care. The responsibility for the care of the patient returns to the PCP after discharge. In this case, the PCP might visit the hospitalized patient, but the visit would be a social or courtesy visit rather than a medical visit.
A third approach is for a PCP to admit to a hospital’s staff hospitalists. The third approach makes the most sense, for most patients. The arguments in its favor are as follows:

1. Patients get round-the-clock access to a physically present provider of medical care.
2. Hospitalists devote all of their attention, every day, to hospitalized patients.
3. The community-based PCP need not feel torn between visiting hospitalized patients and conducting office visits.
4. The expertise of PCPs is not spread thin by the necessity of being experts on tertiary care.
5. Admission and discharge are more efficient because hospitalists are on-site to do the initial and discharge evaluations and order writing.
6. Nursing care is more efficient because nurses need not deal with off-site attending PCPs. At a time when hospital days are being monitored by health plans, it is the hospitalists who have the most potential for keeping utilization at a safe minimum.

There is one strong argument against hospitalists, however. Patients may have established close
relationships with their PCPs and presumably trust their PCPs. When hospitalized, patients may feel more comfortable with their PCPs directing their care. The counterarguments are as follows:

1. There is nothing to prevent PCPs from visiting or calling patients who are hospitalized.
2. The PCPs presumably have chosen competent hospitals with competent hospitalists.
3. Patients are accustomed to being referred to specialists and may likewise feel comfortable with being referred to hospitalists.
4. Many consumers of health care no longer have a close one-on-one relationship with one PCP because they are signed on with a managed care plan that may have teams of PCPs.

Do NPs Need Hospital Privileges for Advancement of the Profession?

There are two arguments supporting the assertion that NPs who wish to be PCPs should seek hospital privileges. First, it is a credential that carries weight among professionals. It is something professional groups boast and battle about and that individual professionals strive for. Physicians sometimes use
NPs’ lack of hospital privileges as an argument that NPs should not be designated PCPs by managed-care organizations. If the majority of NPs had hospital privileges, physicians would not be able to use the hospital privilege argument against NPs.

Second, some health plans and managed-care organizations want their PCPs to have admitting privileges. If that is the case and an NP wants to be a PCP, the NP will need to get hospital privileges.

**Do Individual NPs Need Hospital Privileges?**

The NP who is not required to have hospital privileges to be a PCP may not want them. For an individual NP weighing the pros and cons of hospital privileges, the issues are as follows:

- Whether the NP is qualified to deliver evaluation/management services to patients who are so ill they require hospitalization
- Whether the NP wants to devote the time it takes to make hospital visits every day
- Whether an NP needs hospital privileges to be an effective PCP
- Whether local health plans require PCPs to have admitting privileges
- Whether patients are better served by hospitalists or by attendance of their PCP
- Whether hospitalists are available in a local hospital
- Whether the NP wants to spend the time necessary to keep up hospital privileges (e.g., to attend medical staff meetings and serve on committees)
- Whether NP applications for hospital privileges are being accepted or denied by a local hospital
- Whether the NP is willing to bear the expense of admitting privileges

An NP debating whether to apply for admitting privileges should consider what privileges will allow them to do, what not having privileges will keep them from doing, how difficult it will be to get admitting privileges, and what alternatives there are to the NP’s personally admitting patients to hospitals. The following questions may prove helpful in making a decision:

- Does a managed-care organization with whom the provider wants to associate require admitting privileges?
- Is there a physician with admitting privileges who will take on an NP’s patients when they need hospitalization?
Some NPs have found that the physicians they work with want them to have admitting privileges and that they support those NPs’ applications. In other cases, physicians themselves have decided not to concentrate on admitted patients, but rather to work with other inpatient-oriented physicians to care for admitted patients. Further, while some NPs are educated in acute care–oriented graduate programs, others consider themselves experts on primary care only. Hospital care is, by definition, tertiary, not primary care. An NP may wish to concentrate on primary care and not wish to spread professional interests too thin.

Finally, an NP should look at the economics of taking on hospital visits. Managing hospitalized patients can take a large portion of an NP’s day, and if there are few patients in the hospital, reimbursement may not be rewarding. For example, if a hospital visit brings in $75 but it takes 15 minutes to see a patient, 5 minutes to discuss the care with nursing staff and/or write orders and notes, and 20 minutes each way to commute between the office and hospital, an NP will net only $75 per hour. In the office, an NP can bring in at least $78 per 20-minute visit, or $234 per hour. A
hospitalist physician or NP can bill $75–82 for the 20-minute hospital visit but can also bill at least $75 for visits to other hospitalized patients and can bring in at least $225 per hour.

**Who Has Hospital Privileges?**
Traditionally, only physicians had hospital privileges. Privileges were granted or denied on the basis of criteria to which only the hospital and physicians involved were privy. Physicians who were denied hospital privileges—often not because of any lack of expertise, but because a hospital already had one endocrinologist or one radiation oncologist—sought admission by suing the hospital or lobbying for legislation requiring impartial third-party review of hospital privilege denials. For example, the following New York law protects physicians, podiatrists, optometrists, and dentists from discrimination by hospitals in the matter of staff privileges:

> It shall be an improper practice for the governing body of a hospital to refuse to act upon an application for staff membership or professional privileges or to deny or withhold from a physician, podiatrist, optometrist, dentist or licensed midwife staff membership or professional privileges.
in a hospital, or to exclude or expel a physician, podiatrist, optometrist, dentist or licensed midwife from staff membership in a hospital or curtail, terminate or diminish in any way a physician’s, podiatrist’s, optometrist’s, dentist’s or licensed midwife’s professional privileges in a hospital, without stating the reasons therefor, or if the reasons stated are unrelated to standards of patient care, patient welfare, the objectives of the institution or the character or competency of the applicant. It shall be an improper practice for a governing body of a hospital to refuse to act upon an application or to deny or to withhold staff membership or professional privileges to a podiatrist based solely upon a practitioner’s category of licensure.

*Citation:* N.Y. Pub. Health Law § 2801-b.1.

The law also states that if a hospital does not follow proper procedure, the physician, podiatrist, or other healthcare professional may file a complaint with the
public health council, which will make a prompt investigation and may recommend that the hospital review its actions (N.Y. PUB. HEALTH LAW § 2801-b.2 and 3).

Historically, dentists, podiatrists, optometrists, and clinical psychologists did not have admitting privileges. Recently, those professions have made progress in obtaining hospital privileges. Their organizations and individuals applied pressure through the courts and the legislature, and eventually, in some states at least, they gained admitting privileges.

Nurse midwives have admitting privileges in some states. For example, in Oregon, nurse midwives (and NPs) have had statutorily permitted hospital privileges since the mid-1970s. The permissive legislation was passed at a time when midwives were needed in rural areas because obstetricians found that malpractice insurance was too expensive so they gave up delivering babies. The Oregon legislature was convinced that nurse midwives needed admitting privileges to make sure rural Oregonians could have attended deliveries. When the issue came before the Oregon legislature, the Oregon Nurses Association suggested that the legislature take the opportunity to permit all NPs, not
just nurse midwives, to have admitting privileges. The bill passed. The law states:

The rules of any hospital in this state may grant admitting privileges to NPs licensed and certified under ORS 678.375 for purposes of patient care, subject to hospital and medical staff bylaws, rules, and regulations governing admissions and staff privileges.

Rules shall be in writing and may include, but need not be limited to:

- Limitations on the scope of privileges;
- Monitoring and supervision of nurse practitioners in the hospital by physicians who are members of the medical staff;
- A requirement that an NP co-admit patients with a physician who is a member of the medical staff; and
- Qualifications of NPs to be eligible for privileges including but not limited to requirements of prior clinical and hospital experience.
The rules may also regulate the admissions and conduct of NPs while using the facilities of a hospital and may prescribe procedures whereby an NP’s privileges may be suspended or terminated. However, a hospital may refuse privileges to NPs only on the same basis that privileges are refused to other medical providers.

**Does Federal Law Support Full Hospital Privileges for NPs?**

Federal law states that every hospitalized patient covered by Medicare must be under the care of a physician (42 U.S.C.S. § 1395x[e][4]). The federal government has defined physician as a licensed doctor of medicine, osteopathy, dental surgery or dental medicine, podiatric medicine, chiropractic, or optometry (42 C.F.R. § 410.20). In 1994, clinical psychologists pushed through an amendment to the Social Security Act to add language to federal Medicare law that allows hospitalized patients to be under the care of a clinical psychologist (42 U.S.C.S. § 1395x[e][4]).

A federal regulation allows physicians to “delegate tasks to other qualified healthcare personnel to the
extent recognized under State law or a State’s regulatory mechanism” (42 C.F.R. § 482.20).

NPs who deliver care to hospitalized patients presumably fall under the delegation rule. While an NP who has admitting privileges may admit patients, there must be a physician’s name on the patient’s record, as “attending,” in order to comply with the federal law cited earlier.

What Does It Mean to Have Hospital Privileges?

When a patient is admitted to a hospital, the admitting provider is the contact person for the hospital regarding the patient’s care while hospitalized. Reports are given to the admitting provider, and it is agreed that decisions, such as readiness for discharge, will be made by the admitting provider.

Unless a provider has privileges, some hospitals will not allow that provider to review a patient’s chart, much less order treatments. Part of the rationale for this is patient confidentiality. It is the hospital’s responsibility to protect the confidentiality of admitted patients. There have to be limits set regarding who can have access to confidential documents. It would be inefficient for an
administrator or nurse to have to decide on a visit-by-visit basis whether any particular provider should have access to patient records. Therefore, hospitals have developed systems for granting admitting privileges to providers who have been screened and credentialed. By hospital policy, providers with privileges have full access to information about the patients they admit, as well as decision-making and ordering authority.

Levels of Privilege
Hospitals may have levels of privileges, which they may designate as associate, affiliate, independent, or some other term.

Associate privileges may mean that privileges are less than full. For example, providers who have associate privileges may be able to review the records but not write orders, or they may be able to review charts and write orders but not admit. Each hospital has its own policies on this matter. Some NPs who have admitting privileges have full privileges, and some NPs have limited privileges.

The Application Process
The medical staff governing body—traditionally physicians—decides which other providers may have hospital privileges. The medical staff
governing body is a separate entity from hospital administration. It may be subject to the requirements of accreditation organizations, state laws, and federal laws.

Competency and experience are the general criteria that a medical staff group will look at in granting or denying privileges. Many hospitals require an applicant to be recommended by a current member of the medical staff, and, after research into credentials is done, a vote is taken on the applicant. This club-type aspect of the privileging process has resulted in some qualified applicants being denied privileges because of noncompetency-related issues, such as competition, personal bias, or prejudice.

Physician-oriented professional associations often have taken on the task of urging that privileging decisions be based on competency rather than friendship or lack thereof. Accrediting organizations also evaluate the emphasis on competency and experience in a hospital’s privileging process as part of the accreditation review.

**Expense**
There may be an application fee or annual fee for hospital privileges.
Denial of Privileges
Some NPs have had admitting privileges for years. Others are applying for and receiving admitting privileges currently. Some NPs have lost their admitting privileges after leaving physician practices. Some NPs have been denied privileges altogether.

While there is a multitude of reported court decisions regarding other classes of healthcare providers who were denied privileges—family physicians, optometrists, and chiropractors, for example—there are no tradition-changing opinions regarding denial of admitting privileges to NPs.

Federal law regarding conditions of participation in Medicare states that a medical staff governing body must ensure that “the accordance of staff membership or professional privileges in the hospital is not dependent solely on certification, fellowship, or membership in a specialty body or society” (42 C.F.R. 482.12[a]7).

It is not clear how this law relates to nonphysicians. In 2012, the Centers for Medicare & Medicaid Services (CMS), in a Final Rule, declined to require that hospitals include nonphysician practitioners on medical staff; however, in that Rule, CMS stated
“Medical staffs must be representative of all types of health professionals who have privileges, including Advanced Practice Registered Nurses (APRNs) and Certified Nurse Midwives/Certified Midwives (CNMs/CMs), and who provide services to a hospital’s patients, and as they are authorized to provide services under State law and to the extent of their full scope of practice.”

Change on the Horizon
Hospitals are consolidating, merging, and closing. Because hospital admissions are declining around the nation, hospitals are seeking new service lines. It is in the interest of hospitals to draw patients from as many sources as possible. Therefore, hospitals may open their staff privileges to more classes of healthcare providers. If an NP decides he or she needs hospital privileges, the NP should call the intended hospital, ask about the process, and apply.

Note
Chapter 7: Negligence and Malpractice

Nurse practitioners (NPs) carrying out their daily routines have one constant on their everyday to-do list: “Do no harm.” Nevertheless, when an NP, or any other healthcare provider, makes hundreds of decisions a day, it is inevitable that mistakes will be made.

For example, researchers studying medical errors at a major teaching hospital followed nurses and doctors for 9 months on three surgical units. They found that some medical error was made with almost half of the patients and that for at least 18% of the patients there was a serious consequence. Only 1% of these patients sued for malpractice, however.¹

Though malpractice lawsuits against NPs are rare, the financial and emotional sequelae of being sued are so dire that it is worth dealing with this subject in depth. The meaning and incidence of lawsuits
against NPs are difficult to state accurately, for a variety of reasons.

First, a filed lawsuit has no meaning other than to state that a person believes himself or herself to have been harmed. The belief may be unfounded. The blame may be placed on the wrong person. The complaint may not even meet the definition of malpractice. Thus, tracking the incidence of filed suits is of very limited value.

Second, some suits that are filed and that name NPs do so not because the plaintiff believes an NP caused harm but because an NP is a member of a team of caregivers who are being sued, and at the early stages of a lawsuit it is not clear who is responsible. On the other hand, some NPs who actually have been negligent may not be sued, for a variety of reasons.

Third, unless an insurance company reports a damage award—a successful lawsuit or a settlement for damages—against an NP to the National Practitioner Data Bank (NPDB), a lawsuit may come to light only through a search of county court or insurance company records. Insurance companies are required to report damage awards to the NPDB. If a suit is filed but the plaintiff is
unsuccessful in proving the necessary elements for malpractice, there will be no report filed with the NPDB. Keeping a national tally of unsuccessful lawsuits filed against NPs is almost impossible.

That being said, one study comparing the incidence of successful lawsuits against advanced practice nurses (APNs), physicians, and physician assistants (PAs) found that in 2006, the chances of paying a malpractice award were 1 in 62 for physicians, 1 in 563 for PAs, and 1 in 1,016 for APNs, based on the ratio of awards divided by the number of licensed providers.\textsuperscript{2} The incidence of malpractice lawsuits in which nurse practitioners have been named as the primary defendant remains low, at 2%.\textsuperscript{3}

**What Can Happen to an NP Who Is Sued?**
An NP who is sued may feel like leaving the profession, doubt his or her ability to make decisions, or resort to overreferring and seeking unnecessary consultation. In addition, the NP may find that his or her insurance rates are increased, may miss days of work while testifying, may have to pay some legal expenses, and may have to mount a defense before the state licensing board.
Boards of nursing do not automatically investigate NPs who have lost malpractice lawsuits. However, if someone involved with the case reports the NP to the board of nursing, or the negligence approaches the level of gross negligence, the board of nursing likely will investigate. Gross negligence, for a professional, is the intentional failure to perform a professional duty in reckless disregard of the consequences.

**Life Cycle of a Lawsuit**
A lawsuit starts with the filing of pleadings with a state court, usually in the county where the incident occurred. Some states direct malpractice actions to an arbitration panel. The case is presented to the panel, and its members make a decision in favor of one party. Depending on state law, either party may appeal, in which case there will be a trial. At trial, a judge or jury decides in favor of one party. Either party may then appeal to a higher state court. Rarely, a party will seek an appeal to a federal court. Federal courts may accept or refuse appeals from the state courts. Although it is possible that a malpractice case could go all the way to the U.S. Supreme Court, it is highly unlikely. Usually, the highest state court of appeals is the highest level of consideration of a malpractice case, and often the parties will let the matter drop after the state trial
court case. Because the holdings of state trial courts are not published, the public cannot easily access information on malpractice trials unless there is an appeal. The opinions of appeals courts are published, and that is the information attorneys and professionals can use to gain insight into malpractice cases.

What Is Malpractice?

_Malpractice_ is the failure of a professional to exercise that degree of skill and learning commonly applied by the average prudent, reputable member of the profession. Negligence is the predominant legal theory of malpractice liability. Negligence includes failure to follow up, failure to refer when necessary, failure to disclose necessary information to a patient, and failure to give necessary care.

Elements of Malpractice

A plaintiff in a malpractice suit must prove the following elements:

1. The NP owed the plaintiff a duty.
2. The NP’s conduct fell below the standard of care.
3. The NP’s conduct caused the plaintiff’s injury.
4. The plaintiff was injured.
Duty
A duty is established when there is a provider–patient relationship. A visit to the NP’s office by a patient establishes an NP’s duty to that patient. However, there need not be an office visit to establish duty. Duty can be established by a telephone conversation or casual discussion with a patient or with someone who is not officially a patient. If an NP gives professional advice or treatment in any setting, a duty may be established. If an injured party has reason to believe that there was a provider–patient relationship, there may in fact be such a relationship, even if the provider did not think of the interaction in that way.

What Is the Standard of Care for NPs?
NPs are duty bound to use such reasonable, ordinary care, skill, and diligence as NPs in good standing in the same general type of practice in similar cases.

An NP is held to the standard of care of a reasonably prudent NP, not necessarily to the standard of care expected of a physician. In many situations, however, the standards of care for physicians and NPs will be identical. For example, an NP providing primary care can be held to the
same standard as a physician providing primary care.

If an NP is sued for malpractice, the standard of care will be argued in court. If an NP believes that she or he met the standard of care, the NP’s attorney will enlist expert witnesses, usually other NPs, who will give testimony describing the steps that a reasonably prudent NP would take in a similar situation. The plaintiff’s attorney also will enlist expert witnesses, who can be expected to testify that the standard of care called for measures other than those performed by the defendant NP. A judge or jury will accept either the plaintiff’s or the defendant’s explanation of the standard of care and will then decide whether the defendant NP met that standard.

**Causation of Injury**

For malpractice to have occurred, a breach of the standard of care must have caused an injury to the plaintiff. For example, an individual visits an NP and is diagnosed with otitis media. The NP prescribes penicillin, to which the patient is allergic. This allergy is marked on the patient’s chart. The patient leaves the clinic with penicillin, but before she takes it, she is stung by a bee on the front steps of the clinic. She has an allergic reaction to the bee sting and falls
and hits her head, causing a permanent scar on her face. The patient sues the clinic and the NP, claiming that the NP had a duty to the patient, the NP breached the standard of care (by prescribing penicillin for a penicillin-allergic patient), and the patient suffered an injury. All of these claims are true, but there is no malpractice because the breach of the standard of care (prescribing penicillin to an allergic patient) did not cause the injury (the wound to the head).

**Injury**
A provider may be terribly negligent, but if there is no injury, there is no malpractice. For example, if an NP prescribes penicillin to a patient who is allergic, and the patient takes the penicillin but has no reaction that injures her or him, then there is no malpractice, even though the standard of care has been breached and even though, if an injury had occurred, there would have been a causal relationship between breach of the standard of care and injury.

**Examples of Lawsuits Against NPs**
**Missed Diagnosis**
**Example 1**
A 31-year-old man, a truck driver with a history of using chewing tobacco and heavy caffeine, presented to a primary care physician’s office with complaints of abdominal pain, burning and cramping, and inability to eat. He had a family history of colon cancer. He was seen by an NP, who prescribed Zantac. A follow-up examination was scheduled, and at that visit, he complained of abdominal pain and increased stools. The NP changed his medication and ordered an upper GI series. It was negative. The NP did not perform a rectal exam nor send him for a colonoscopy.

Two months later, the patient presented again, complaining of continued eating problems. The nurse practitioner diagnosed gastritis with instructions to follow-up in 6 months. Six months later, he presented with complaints of increased stomach cramping and burning. The NP changed his medication and referred him to a gastroenterologist. He returned prior to that appointment, again complaining of worsening cramping pain and loose stools. The NP diagnosed gastritis and ulcer with nicotine addiction. He was given an earlier appointment with the gastroenterologist but due to extreme pain he instead went to an emergency department. There, an abdominal CT scan and colonoscopy showed
Stage IV colon cancer, causing a near complete blockage of the right side of his colon. The cancer had metastasized.

Despite surgery and chemotherapy, he died within 2 years of diagnosis. His family sued the NP and the primary care physician, alleging negligence in failing to diagnose cancer in a timely manner. Expert witnesses, including another NP, testified that given his complaints of abdominal pain, increased stools, and family history of colon cancer, the NP departed from the standard of care by failing to perform a rectal exam, obtain stool for occult blood test, or order a colonoscopy. A gastroenterologist testified that because a negative upper GI showed the esophagus, stomach, and small intestines were all normal, a colonoscopy was mandated. An oncologist testified as to the decrease in chance of survival as a result of the delay in diagnosis and treatment. An economist testified that the loss of income and household services was $2 million.

The defendants denied that they had deviated from the standard of care. They maintained that his symptoms did not warrant a colonoscopy because burning pain is more consistent with an upper GI process. They said his history of chewing tobacco and caffeine accounted for his eating difficulties.
The physician said a random review of patient files constituted adequate supervision. An oncologist testified that the patient already was at Stage IV at the time of first presentation, so nothing the defendants did or failed to do caused him damage.

A jury found for the plaintiff. Both defendants were found liable. The jury decided the patient would have had a 45% chance of survival if he had been diagnosed in a timely way, and they awarded damages of $4.6 million.

What NPs Can Learn from This Case
1. The NP saw the patient four times for the same problem before referring. That is probably two visits too many before referral, given the problem was not resolving.
2. The NP didn’t perform a rectal exam nor check for occult blood, even though the patient complained of increased stools. If the NP had done a rectal exam and the results were positive, the NP may have referred the patient earlier. If the results were negative, that would have helped defend the NP.
3. The NP may have been distracted from thinking about colon cancer given the patient was so young. We learn to consider that diagnosis even in a young person.
4. The patient had a family history of colon cancer, so the NP should have considered that diagnosis and ruled it out.

5. When a patient has abdominal complaints, we are reminded that clinicians need to look at both ends of the digestive tract. Starting with the upper end was reasonable, but if findings are negative, then the NP would want to evaluate the lower end.

6. Some juries will hold a physician collaborator or employer liable for an NP’s mistake, even if the physician did not evaluate the patient nor consult with the NP.

Example 2
A boy didn’t feel well at school on a Thursday, and his teacher sent him to the school nurse. She took his temperature, which was normal, and called his mother to come pick him up. His mother took him to a federal health center, and he was seen by NP A. He complained of left groin pain, 3 on a scale of 1 to 10, for 2 days. He had injured his hip playing sports, he said. She diagnosed muscle strain, injected a nonsteroidal anti-inflammatory medication, prescribed an oral anti-inflammatory medication, and told him to apply ice. The next day his mother called the clinic and was told to give him liquid acetaminophen, which she did. On Saturday, his
father brought him back to the clinic. He was seen by NP B. The boy reported left hip pain, severity 10. He said he was unable to walk. An X-ray showed no fractures. The NP ordered a complete blood count (CBC) and sedimentation rate. White blood cells (WBCs) were 6.1 (normal), granulocytes were 95.1% (high), and lymphocytes were 2.9% (low). Sedimentation rate was 18 (high). His temperature was 94.7ºF. During the NP’s exam, the boy developed a skin rash. According to the NP and a physician, the physician then examined the boy; however, there was no note by the physician in the chart, only a signature alongside the NP’s notes. There was no notation under “Exam” about whether the boy could bear weight or walk; however, his weight was “deferred,” leading the judge to conclude that the boy couldn’t bear weight. The NP noted he had a fine hand tremor. A CT scan showed fluid around the left great trochanter, which the radiologist noted could be bursitis or a bursal tear. The NP made an appointment for the boy with an orthopedist for Monday. Sunday morning, the boy had trouble breathing and severe pain in his left hip, so his father took him to a hospital. The boy was found to be profoundly neutropenic and in septic shock. His diagnosis was septic hip. He spent 2 months in intensive care, where he died. The family sued the federal government, operator of the health
center. A judge held an NP’s employer liable for $1.9 million in damages.\textsuperscript{5}

The plaintiff’s expert and the judge found NP B’s care deficient in many ways.

In the history, the NP did not:

- Record the last dose of any meds during initial history taking. (Last-dose information might have been helpful in determining whether fever was masked by acetaminophen.)
- Determine whether the patient had had an infection recently.
- Dissect the rash as a symptom.
- Document negatives, only positives.

In the exam, the NP did not ask the patient to try to walk and then record the findings.

In the medical decision making, the NP did not order tests that would have ruled out sepsis or septic hip. When the radiologist reading the CT scan found fluid adjacent to the left trochanter, the plaintiff’s expert witness said that called for an urgent aspiration of the fluid and analysis. (The NP testified that she had thought of that and that it would be covered in his visit with the orthopedist on Monday. However, when she set up the orthopedic
appointment, she didn’t tell the specialist that she suspected infection and that the patient was unable to walk. In addition, the medications she ordered didn’t address infection. She testified that she didn’t want to initiate antibiotics without knowing what she was treating.) To rule out sepsis, the NP had the following options, according to the expert: throat culture, blood culture, C-reactive protein, magnetic resonance imaging (MRI), and analysis of hip fluid. Aspiration and blood culture would be the gold standard. The expert said the NP could have first performed three tests on-site or referred the patient elsewhere for immediate aspiration and MRI.

**What NPs Can Learn from This Case**

1. A change in vital signs (in this case an increase in heart rate and decrease in blood pressure) must be considered. NP B didn’t retrieve the chart from the visit with NP A from 2 days before, so he or she didn’t know that the patient’s vitals had changed significantly. The take-home message is always access the old chart and attend to changes in data since the last visit.

2. After noting fine hand tremors, NP B checked vitals again, suspecting fever, but found none. Absence of fever doesn’t carry diagnostic weight if the patient has been on
acetaminophen. The plaintiff’s expert testified that NP B should have suspected septic hip. The lesson for clinicians is consider all of the data when including or rejecting diagnoses and initiating the treatment plan.

3. When a physician testifies years after a visit that he was involved and he provides specifics, but didn’t document anything, the physician’s credibility is damaged. The physician testified that he examined the patient and provided significant detail about the case. He also testified that he didn’t actually recall the visit. The judge found him lacking in credibility. We learn that a physician’s signature on a note, with nothing more, does nothing to help the NP, the physician, the patient, or subsequent caregivers.

4. A normal WBC with left shift indicates infection. A decrease in lymphocytes indicates bacterial rather than viral infection. An elevated sedimentation rate indicates bacterial infection. (All of this is from the expert’s opinion.)

5. Inability to bear weight should have led the NP to evaluate for septic hip. Either NP B didn’t suspect septic hip and should have or
she did suspect septic hip and didn’t refer the boy quickly enough.

Example 3
A 15-year-old female, complaining of a severe headache, left school early one February day. Her mother gave her Tylenol and took her to see an NP that evening. The teenager also complained of very stiff joints, aches, and fever. Her mother stated she had to assist her daughter to the examination room. The NP noted a temperature of 103.7°F, no cough, no chest congestion, no rhinitis, and no abdominal complaints. A complete blood count showed a white cell count of 16,600. The NP performed tests for meningeal irritation but found none. A pediatrician working in the practice conducted a “ cursory observation of the patient at the end of the visit,” according to the plaintiff’s attorney’s report of the case. The NP diagnosed probable influenza, told the patient’s mother to call if the girl vomited or showed other changes in symptoms, and sent the patient home. At 7:00 p.m., the mother phoned the office to say her daughter had vomited several times. The NP advised the mother to keep the girl at home for the night and bring her to the office in the morning. The mother and daughter arrived at 9:00 a.m., at which time the daughter was lethargic to the point of being only marginally responsive. Staff
called 911. At the hospital, the girl was diagnosed with meningitis, put on antibiotics, intubated, and admitted to intensive care. She continued to deteriorate, endured brain herniation, and died 1 week after the initial visit. The plaintiff’s attorney alleged that the NP must have improperly performed the tests to elicit signs of meningeal irritation because it was certain that the patient had unusual neck stiffness. The NP denied any negligence, arguing that the girl had influenza, which quickly progressed overnight into meningitis. The parties settled the case for $500,000.6

What NPs Can Learn from This Case

1. Short of lumbar puncture, there is no reliable test for meningitis. Fever, chills, headache, nausea, vomiting, myalgia, anorexia, malaise, irritability, and diarrhea are often seen in influenza and other viruses. Neither Kernig’s nor Brudzinski’s sign is a sensitive test (5% sensitivity), and experts warn clinicians not to rely on either. Headache has a sensitivity of only 50–60% for meningitis. Nausea and vomiting have a sensitivity of 30–50%, depending on the study. Lumbar puncture carries its own risks, and not every clinician feels safe performing one in the office. The clinician must weigh the risk that the patient...
has meningitis against the risk of lumbar puncture and is often in the position of needing to recommend lumbar puncture on a patient who may, in the end, have a more benign condition. One expert recommends performing a CT of the brain to exclude mass lesions, followed by lumbar puncture, when meningitis is suspected.

2. There are two points at which the NP should have considered meningitis seriously enough to send the patient to the emergency room. First, severe headache, accompanied by a fever of 103.7°F, should have raised suspicion. Because stiff neck and mental status change are indicative of meningitis, the NP should have focused on these elements. A second red flag was the report of vomiting at 7:00 p.m. The NP should have advised a trip to the emergency department.

3. The NP should have performed a jolt maneuver.

4. The NP should have said something like “You say your headache is severe, and you have a fever. That could mean meningitis. The only way to really know whether you have meningitis is to do a lumbar puncture. That procedure has its own risks, which are [supply the risks]. If you have meningitis, we
have to get you on antibiotics right away, because this illness can be fatal. So I am recommending that you go to the emergency room” [or “that we perform a lumbar puncture in the office”]. The NP should have documented this advice and the mother’s response.

5. The NP told the mother to call if the girl vomited. She vomited, the mother called, and the NP seemed unconcerned. If warning a parent of ominous signs, be prepared to act promptly when the parent reports the presence of those signs.

**Failure to Refer**

**Example**

A young man went to an emergency room with acute pain caused by testicular trauma after being hit by a softball. He was urinating blood. He was evaluated by a family NP, who prescribed hydrocodone and naproxen. He was discharged 3 hours later with advice to keep ice on the injury and to schedule an elective ultrasound in 2 days. The patient had increasing pain, and his right testicle continued to swell. He returned to the emergency department for reevaluation. An emergency room physician immediately obtained a testicular ultrasound after an examination, which revealed
significant bruising, swelling, and tenderness. The ultrasound revealed an adjacent hemorrhage, or hydrocele. There also was questionable arterial flow to the right testicle. The physician recommended that the patient urgently see a urologist. The urologist admitted the patient for an immediate scrotal exploration and thereafter concluded that the right testicle was ruptured and not viable. The testicle was removed. The urologist’s operative report included a comment that he may have been able to save the testicle if he had seen the patient on the day of the accident. The patient sued the NP, alleging negligence in the failure to order and review a testicular ultrasound before his discharge at the initial presentation. The plaintiff also claimed that the NP should have referred him to a urologist the same day. The defendant argued that the testicle may not have been salvageable even with earlier surgery. The parties settled for $100,000. 

What NPs Can Learn from This Case

1. Know when to refer. Refer when the possibility of severe patient injury is high (testicular trauma, urinating blood, potential for loss of testicle) and the NP’s expertise does not extend to the body area or system affected. (Urologic injuries are not something
most PCPs are expert at evaluating and managing.)

2. If deciding to evaluate an injury yourself rather than refer, order the test most likely to rule out the worst possibility and then follow up.

**Mishandling of Medication**

**Example 1**

A 49-year-old woman was attacked while at work at a psychiatric clinic. Her attacker was a patient, a schizophrenic woman who had become paranoid, psychotic, and convinced that someone was following her and possibly trying to kill her. The patient entered the clinic, filled out some paperwork, and then pulled a butcher knife out of her handbag and repeatedly stabbed the staff person. The employee suffered wounds to her hands, arms, face, eyes, torso, heart, lungs, liver, bowels, buttocks, and vagina, and she lost her eyesight as a result of the attack. The patient had a well-documented history of chronic schizophrenia and noncompliance with medications. She had a history of violent behavior. Her last psychotic attack had resulted in involuntary commitment. During her hospitalization she did not recognize the need to take medications. She was assessed as a moderately high risk of danger to others. She was
released to the care of a community psychiatric clinic and saw an NP there. The NP had not reviewed the patient’s history completely and lowered the dosage of antipsychotic medication because the woman said she did not like taking the medications. The injured worker sued the clinic. The parties settled for $5.5 million. A portion of the settlement was paid to an employee who witnessed the attack and suffered post-traumatic stress disorder due to seeing her coworker lying on the floor disemboweled with her eyes gouged out.8

What NPs Can Learn from This Case
Individuals with schizophrenia may not want to adhere to a prescribed regimen for a variety of reasons. While patient requests normally deserve consideration, when the patient is being treated for psychosis, there is justification and even necessity for refusing to comply with the patient’s wishes. When a clinician encounters a recently discharged psychiatric patient who has been prescribed a medication regimen, it is a breach of the standard of care to decrease dosages without discussion with and approval from the patient’s team, which should include the psychiatrist who supervised the patient’s care in the hospital. There are a number of considerations clinicians should address related to
decreasing antipsychotic medications, including the following:

- Likelihood of psychotic relapse
- SSRI discontinuation syndrome
- Antipsychotic discontinuation syndrome
- Anticholinergic withdrawal reaction
- Withdrawal dyskinesia
- Rebound dystonia
- Potential for adverse events related to abrupt discontinuation (e.g., dizziness, lightheadedness, nausea, tremors, insomnia, sedation, electric shock–like pains, and anxiety)

Another lesson: Spend the time to get old records on patients.

**Example 2**
A patient was seeing two NPs—a family NP and a psychiatric NP—at the same clinic. The psychiatric NP started the patient on lamotrigine, for depression. One week later the patient visited the family NP for evaluation and management of hypertension. Two weeks later the patient visited the family NP again, with a complaint of body aches. The family NP prescribed an antibiotic. One week later the patient telephoned the family NP and complained of a skin rash. The family NP believed the rash was related to a medication. She reviewed
the medication list, which included lamotrigine, but didn’t associate that medication with the rash. The patient finished the antibiotic, continued the lamotrigine, and continued to have the skin rash. She visited the family NP a few days after completing the course of antibiotics. The family NP prescribed a steroid for the inflammation. She also referred the patient to a dermatologist, who told the patient to discontinue the lamotrigine immediately. Two days later the patient was diagnosed with Stevens-Johnson syndrome and hospitalized. The condition progressed to toxic epidermal necrolysis. The patient was hospitalized for 3 weeks.

The patient sued the family NP for failing to diagnose and treat Stevens-Johnson syndrome. The NP testified that she believed she was not responsible for attending to the side effects of medications prescribed by others. A jury, and later the Missouri Court of Appeals, found that testimony damning. The court said the family NP was aware the patient was on lamotrigine and that standard reference materials available to her would have alerted her to the possibility of Stevens-Johnson syndrome. The jury awarded the patient $525,000 in damages.9

What NPs Can Learn from This Case
1. Primary care providers are responsible for taking the patient’s total picture into account when evaluating and managing a symptom or sign. Any medication on the patient’s list could be the cause of a side effect, and the psychiatric medication should have been considered as the source of the rash and discontinued. Specialists also must consider the side effects of medications prescribed by others if a patient reports a sign or symptom. In this case, the psychiatric NP was neither faulted nor sued. One reason for this was the patient did not communicate complaints about the rash to the psychiatric NP. The psychiatric NP had entered lamotrigine appropriately on the medication list and, if the patient had contacted the psychiatric NP, that would have triggered the psychiatric NP’s responsibility to deal with the side effect. If the family NP had alerted the psychiatric NP about the rash, then the psychiatric NP would have been responsible for taking action. However, one could argue that the psychiatric NP could have been assigned liability because she should have alerted the patient, at the time of prescribing, about the possibility of a Stevens-Johnson reaction and advised the patient about what to do if the patient
developed a rash. Psychiatric NPs prescribing lamotrigine can decrease risks by informing patients of the possibility of a Stevens-Johnson reaction and advising patients to report a rash to the NP.

2. All NPs should be able to recognize the potential for and presentation of Stevens-Johnson syndrome because it can be activated by many medications.

3. While fully developed Stevens-Johnson syndrome has distinctive skin signs that are difficult to forget, apparently an early-onset Stevens-Johnson rash can look like the more benign form of dermatitis caused by antibiotics.

4. Even though an early Stevens-Johnson rash may be indistinguishable from a more benign rash, advise a patient complaining of rash to come to the clinic rather than attempting to diagnose by telephone.

**Failure to Provide Preventive Care Example**

A 35-year-old woman visited a primary care physician’s office for various ailments in 2001 and 2002. She saw a primary care physician twice and an NP four times. The patient had a history of splenectomy in 1985. She had received Pneumovax
following the procedure. She did not receive haemophilus or meningococcal vaccination. Subsequent to 2002, the patient developed a pneumococcal infection that required a 3-month hospitalization and a 2-month stay in a rehabilitation facility. During the hospitalization, she became septic, suffered organ failure and necrosis, and had partial amputation of toes. She can now walk only short distances and suffers from chronic infections and pain. The patient/plaintiff contended that the standard of care required the defendants to revaccinate the patient with a Pneumovax booster due to her asplenia. The plaintiff contended that if the defendants had complied with the accepted standard of care, then she would have avoided her subsequent pneumococcal infection. The clinicians argued that the patient’s visits had all been for acute sick visits, not annual preventive and wellness physicals, which did not provide them with an opportunity to recommend or administer a pneumococcal vaccination. The defendants also claimed that the pneumococcal vaccination is not the standard of care, is not proven effective, and would not necessarily have prevented the plaintiff’s infection. The parties reached a $3 million settlement.\(^8\)

**What NPs Can Learn from This Case**
Generally, patients get one Pneumovax per lifetime. However, patients without spleens need special consideration. The standard of care is to revaccinate asplenic patients. Furthermore, patients who come only for “sick visits” and never get a preventive care evaluation are risks to themselves and to their healthcare providers. The clinician who wants to decrease risk will either make time during sick visits for attention to preventive matters or will insist that all patients schedule a preventive visit every 1–3 years.

**Failure to Perform Routine Screening**

**Example**

A child visited a primary care center from birth to 9 months. At one visit (the case report does not specify the age of the child at this visit), the child’s mother pointed out to an NP that one of the child’s pupils was larger than the other. Two months later the parent told the NP that the child’s eyes did not move in tandem. The parent claimed the NP said these symptoms were not important. Three months later the NP tested the child for red reflex. The NP saw no light reflected back and referred the child to an ophthalmologist, who diagnosed retinoblastoma in both eyes. One eye was removed 3 months later and the other 3 years later. The mother claimed that
the NP should have tested for red reflex earlier, which would have saved one eye. The mother admitted that one eye would have been lost in any event. The parties settled for $2 million.

What NPs Can Learn from This Case
Understand the standard of care for routine screening for your population. The standard of care calls for an NP or physician to perform a red reflex examination at every well-child visit until a child can read. One source of the standard of care is the American Academy of Pediatrics (AAP). Here is a summary of the AAP recommendations:

All neonates, infants, and children should have an examination of the red reflex of the eyes performed by a pediatrician or other primary care clinician trained in this examination technique before discharge from the neonatal nursery and during all subsequent routine health supervision visits.

Telephone Triage Example
A 9-year-old boy who was thought to be previously healthy developed nausea and vomiting, poor
appetite, lethargy, and weakness over 3 days. The boy’s father called the pediatrician’s office on a Saturday night. An NP was on call. When the NP returned the call, the father said the boy had slept for 24 hours straight but had been carried downstairs to watch TV and was sipping ginger ale. He had had some rectal bleeding and some bleeding from his mouth in the past day.

The NP told the boy’s father it sounded like a viral illness, but that the rectal bleeding could be something different. She asked:

- Was he alert? Father said yes but very tired.
- Had he passed any urine? Father said yes.
- Did he have a fever or rash? Father said no.

Then the NP asked the father whether he thought the child needed to be seen right away. The father said he thought it could wait until morning. The NP made plans to see the father and son after 8:00 a.m. She instructed him to call back if anything developed during the night. The NP told the father to push the ginger ale and make sure the boy was urinating.

There was an audio recording of the call. The NP documented her advice in the medical record, including that the father was offered an emergency
department visit. However, the audio recording did not verify a specific offer of an emergency department visit.

When the father checked on the boy at 4:00 a.m., he was sleeping, and the father noted that his breathing rate had increased. In the morning the father again checked, and the boy was not breathing. The father called 911 and started cardiopulmonary resuscitation. When an ambulance arrived the child was apneic and pulseless, with fixed and dilated pupils, and his corneas were cloudy. At 9:30 a.m., the child was pronounced dead. An autopsy found the cause of death to be diabetic ketoacidosis. There was no previous diagnosis of diabetes. His blood sugar was 1,165 (normal is 50–80), potassium was 7.1 (normal is 3.5–5.3), and HgA1c was 15.3% (normal is 4–5.9%).

The parents sued the NP, alleging wrongful death of their son due to negligent delay in diagnosis and treatment of diabetic ketoacidosis. The case was settled for an unknown amount.\textsuperscript{12}

\textbf{What NPs Can Learn from This Case}

1. When taking a call, consider a diagnosis of diabetic ketoacidosis, and query ill patients
about polydipsia, polyphagia, and polyuria, as well as fruity-smelling breath and confusion. The warning signs that this child had more going on than a viral illness were (a) sleeping for 24 hours straight; (b) 3 days of weakness with, it appears, little improvement; and (c) oral and rectal bleeding. These three symptoms or signs don’t point us to diabetic ketoacidosis, however. The boy’s symptoms, so far as they were discussed by the NP and father on that Saturday night, don’t fit neatly with the symptom list for diabetic ketoacidosis. Nor do they fit neatly with a viral illness. While the boy’s symptoms of oral and rectal bleeding and extreme sleepiness and weakness do not fit with either viral illness or diabetes, these problems are worrisome enough to deserve an in-person evaluation.

2. If in doubt about whether a patient’s symptoms are grave, direct the patient to call emergency medical support or visit an emergency department right away. Had this NP had the opportunity to observe and examine the child, it is possible that the NP would have expanded her history taking and urged an emergency department visit so that a clinician could conduct an examination to determine whether the child’s breath smelled
fruity, whether he was confused, whether he was short of breath, and whether his potassium or blood sugar were elevated.

3. Don’t put the decision about whether the situation could wait until morning on a parent.

4. If giving telephone advice, there should be protocols in place as to the questions the provider should ask and when a patient should be referred, and there should be a mechanism to record what was discussed and what advice was provided.

5. Telephone triage adds a significant layer of risk to the already risky business of diagnosing. So when responding to after-hours calls, take thorough histories. When a patient can’t breathe or is bleeding or when a patient who previously could stand on his or her own can no longer do so, recommend an immediate emergency department visit or ambulance call. If this NP had recommended an emergency department visit, most likely the father would have complied. If the NP had recommended an emergency department visit and the audio recording had captured the recommendation, then, even if the father didn’t comply, the NP would have had a sound defense.
The National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) is a repository for damage award data, that is, payments from professional liability insurance companies on behalf of their clients to injured parties for successful malpractice claims. NPDB also records adverse actions against providers by licensing boards, hospitals, and professional quality assurance committees.

The NPDB is the responsibility of the U.S. Department of Health and Human Services. It was established under a law that was intended to encourage hospitals, state licensing boards, and other healthcare entities to discipline those who engage in unprofessional behavior and to restrict the ability of incompetent physicians, dentists, and other healthcare practitioners to move from state to state without disclosure of their previous dangerous performance.

Under the law, any malpractice insurer who pays any amount to a plaintiff on behalf of an NP in a malpractice case must report that payment to the NPDB. If an NP pays an injured patient directly to settle a matter, that payment need not be reported. The insurer must also report damage awards to
state licensing boards. A malpractice insurer must report to the NPDB any amount of dollars paid on behalf of a client to a plaintiff. If a healthcare provider pays an injured party directly, that need not be reported. In addition, state licensing boards are required to report adverse licensure actions, hospitals are required to report adverse clinical privilege actions, and professional societies are required to report adverse professional society membership actions.

Hospitals must check the NPDB data every 2 years before granting clinical privileges. Certain agencies may check the NPDB data. The general public does not have access to the NPDB data. Individual NPs may see their NPDB file and add a brief comment to give their version of an incident listed in the database.

**Working with Practice Guidelines**

An NP may be following practice guidelines as a matter of law, policy, and/or good practice. Some states require an NP to establish practice protocols or guidelines, with or without a physician’s input.

NPs should consult state law to determine whether written guidelines are required. Written guidelines should meet these criteria:
1. Do not write guidelines so detailed that they cannot reasonably be followed in everyday practice.
2. Base guidelines on evidence and widely used resources, and reference those resources in the guidelines.
3. Practices may adopt an already published set of guidelines.
4. Follow the guidelines.
5. If the guidelines are inappropriate for a particular patient, document why an alternative tack is being taken.
6. If guidelines are not followed because a patient will not comply, document efforts to follow guidelines and patient noncompliance.

The federal Agency for Healthcare Research and Quality (AHRQ) publishes evidence-based clinical practice guidelines in the National Guideline Clearinghouse ([https://guideline.gov](https://guideline.gov)). An NP who is caring for patients with a condition addressed by a guideline appearing in the National Guideline Clearinghouse should follow the guidelines or document why the guidelines are inappropriate for a particular patient.

**How to Prevent Lawsuits**
1. Be careful about establishing patient–provider relationships. If an NP gives medical advice to a person, for example, in a social situation, that person is considered a patient, and thus the NP should exercise all of the cautions and standards that he or she would exercise with a patient in an office or hospital setting.

2. Know the standard of care and practice within it.

3. If practice guidelines or protocols have been adopted by the office or agency, follow them.

4. When in doubt, take a conservative approach.

5. Rule out the worst diagnoses early on.

6. Know the limits of training and expertise.

7. Follow up.

**What to Do If Sued**

1. Call the NP’s professional liability insurance company to report the lawsuit.

2. Do not talk about the suit with anyone but the NP’s attorney. Specifically, do not talk with the plaintiff/patient or the plaintiff’s attorney.

3. Consider retaining the NP’s own attorney if the suit is against a group.

4. Never change a record after learning of a lawsuit (or for any other reason).

5. A deposition—a pretrial information-gathering session—can be as important as a trial in
terms of the need for preparation. What an NP says in deposition can lock the NP into what he or she may say at trial.

6. Think carefully before agreeing to settle. Settlement awards will appear on an NP’s NPDB record.

**Communication**
Researchers who compared the time physicians spent with patients with malpractice history found that primary care doctors with two or more malpractice claims against them spent 15 minutes on average with each patient, whereas doctors with no malpractice claims against them spent an average of 18.3 minutes with each patient. Quality-of-care ratings for the sued physicians were as good as ratings for physicians who had not been sued.13

Experienced NPs know that good provider–patient communication means better outcomes and higher patient satisfaction. Good communication also means fewer lawsuits. Satisfied patients generally do not sue.

**Liability of Collaborating Physicians**
In the past, some courts have found physicians liable for the negligent acts of NPs. In the majority of
these cases, there was some element of physician involvement in the misdiagnosis. Nevertheless, physicians cannot expect to be fully free from the threat of lawsuit for the acts of the NPs they collaborate with or supervise until the legal requirements for collaboration are lifted.

Medical practices and agencies that set policies calling for supervision of NPs and other APNs can expect to be held liable when NPs are not, in fact, supervised.

Consider the following example: A Texas hospital had a contract with a group of anesthesiologists to provide anesthesia services. The anesthesia group employed certified registered nurse anesthetists (CRNAs). The contract between the hospital and the anesthesia group stated that all CRNAs would be supervised by the anesthesia group. The hospital’s written policies and procedures required “direct and personal” supervision of CRNAs by physicians. Hospital policy also required that (1) patients be fully informed about the anesthesia providers who would be giving care, (2) an anesthesiologist prepare and evaluate patients about to have surgery, (3) CRNAs document and discuss the evaluation of their patients with a supervising anesthesiologist or
surgeon, and (4) the supervising physician countersign all orders for medications.

One night, a CRNA working without an anesthesiologist on-site attempted to intubate a patient having respiratory distress during a Caesarean section. The CRNA called the anesthesiologist on call to come in right away. The anesthesiologist immediately headed for the hospital. The CRNA eventually was able to intubate, but the patient suffered irreversible brain injury.

The patient and her husband settled with the CRNA and physician. The plaintiff’s suit against the hospital went to trial. The plaintiffs argued that the hospital was negligent for failing to adopt, implement, and enforce appropriate policies relating to providing an anesthesiologist, having an anesthesiologist evaluate the patient, supervising the CRNA, disclosing that a nurse was providing anesthesia, failing to exercise care in credentialing, and failing to ensure proper quality assurance and peer review in the anesthesia department.

The jury found that the hospital had not followed its own policies. The jury also found that the CRNA and physician were not negligent but found that the hospital was negligent, that the hospital’s
negligence was the cause of the patient’s injuries, and that the hospital was liable for the injury to the patient. The hospital appealed the case. The appeals court upheld the jury’s decision.\textsuperscript{14}

A physician is not automatically liable for the negligence of an NP with whom the physician has a written agreement to collaborate when called upon. Generally, some neglect by the physician has to be proven.

On the other hand, if a physician is required, by policy or law, to supervise, then a physician has the responsibilities of supervisors in general. In general, employers and supervisors must determine that their employees or supervisees are adequately trained and competent in the areas in which they practice. If employees or supervisees are not adequately trained or competent, then the employer or supervisor is obligated to provide further training and guidance or to replace the employee or supervisee. If policies are called for, by law or higher policy, supervisors are responsible for ensuring that policies are in place. If supervisors know that policies are not being followed by employees or supervisees, it is their responsibility to monitor supervised personnel until policies are followed or to replace the personnel.
Guidelines for physicians who are required by law or policy to collaborate with or supervise NPs and who want to avoid malpractice based on the negligence of an employed NP include the following:

1. Ascertain that the NP is licensed, and verify the NP’s education, training, and malpractice history.
2. Comanage patients with the NP until the physician can confirm that the NP is professionally competent.
3. Consult state law to determine what is required of a collaborating physician. Conform to state requirements.
4. Consult state law regarding scope of NP practice. Do not encourage the NP to go further than scope of practice allows unless the physician develops written protocols or is physically present.
5. Telephone diagnosis is risky for both the physician and the NP. If an after-hours call is a necessity of practice, establish a second level of call whereby NPs taking calls can get backup.
6. Consult state law to determine whether an NP is independent or dependent on physician collaboration or supervision. If supervision is required by law, determine whether direct or
indirect supervision is required. “Direct supervision” of an NP requires a physician to be immediately and physically available should the need arise. “Indirect supervision” or “general supervision” requires that the physician be on the premises or available by telephone in a timely and consistent manner.

7. If evidence-based clinical practice guidelines or protocols exist, follow them.

8. Consider supporting NP organizations in their efforts to repeal legal requirements of supervision or collaboration. Support legal language that places responsibility for an NP’s actions squarely on the NP. A physician who employs an NP who is independently responsible for her or his actions is less likely to be vicariously liable for an NP’s malpractice, and a physician can spend less time in supervisory activities.

**Malpractice Insurance**

An NP cannot control everything. Everyone makes mistakes. Insurance provides a comfort factor that is well worth the money.

Four frequently asked questions about malpractice insurance are (1) Do I need to have my employer cover me under the hospital/university/practice
policy? (2) Will I be more likely to be sued if I have malpractice insurance? (3) Should I get “claims made” or “occurrence” insurance? and (4) Which company’s policy is best?

Do I Need Insurance If My Employer Covers Me Under the Hospital, University, or Practice Policy?

NPs who treat patients outside of their work settings or who moonlight definitely need individual insurance policies. For example, many NPs are approached by neighbors, friends, and relatives for prescriptions. The wise NP will not only treat each of these encounters as thoroughly as if the friend were a patient at the office (or decline to become involved at all), but also have malpractice insurance to cover the possibility of a mistake.

An NP who neither moonlights nor treats neighbors and friends may still want an individual policy, even if an employer covers an NP under an umbrella policy. Why? Because a lawsuit fractures collegial alliances. The human tendency is to deny one’s own liability and blame others. In such an environment, each healthcare provider needs an advocate to protect his or her interests. Insurance will pay for that defense.
Am I More Likely to Be Sued If I Have Malpractice Insurance?
Possibly, but that is not a good reason to forgo insurance. Patients do not usually know whether an NP has malpractice insurance. An injured patient who consults an attorney usually files suit before the patient or his or her attorney knows the insured status of the healthcare provider being sued. Information about the insurance usually comes out in the discovery process in preparation for trial.

However, an NP who tells patients about his or her malpractice coverage may provide an incentive for a litigious patient or may relieve a reluctant patient from any feeling of guilt over suing a respected healthcare provider.

Should I Get “Claims Made” or “Occurrence” Insurance?
Get occurrence insurance, which covers any incident that occurred while the NP was insured. Under a claims made policy, an NP is covered only when the insurance policy is active, no matter when the incident occurred. If an NP retires, leaves the profession, or no longer has need for active insurance, the NP must nevertheless keep a claims made insurance policy active (pay the premium) to receive coverage for incidents that happened in
years past. A claims made policy is extended through purchasing of a “tail” policy.

**Which Company’s Policy Is Best?**

NPs should choose a company that is located in the United States (in case the NP has to sue the insurance company), has been in business at least 10 years, and has a stable financial rating.

An NP will be able to judge the quality of his or her insurer only after a lawsuit is over. There are no surveys of sued NPs that provide guidance about which company provides the best service.

**Notes**


12. This case is reported by LaValley, D. (2012, February 1). Boy dies after call to NP for flu symptoms. Retrieved from https://www.rmf.harvard.edu/Clinician-Resources/Case-Study/2012/Boy-9-Dies-After-Offhours-Call-to-NP-for-Flu-Symptoms


Resources


Laska, L. (Ed.). *Medical malpractice verdicts, settlements and experts* [Newsletter]. Contact: 1-800-298-6288; 901 Church St., Nashville, TN 37203
Chapter 8: Risk Management

Risk management is what one does to avoid problems later. Compare risk management to preventive medicine; risk management prevents legal problems.

Nurse practitioners (NPs) are at risk for two categories of professional mishap: clinical mishap and business mishap. There can be great overlap between clinical and business problems; that is, a clinical problem can turn into a business problem and then into a legal problem. For example, when an NP makes a clinical error and a patient discovers the error, the patient is quite likely to tell friends, relatives, and coworkers. Then the problem evolves into a business problem for the NP because the friends, relatives, and coworkers of that patient are unlikely to visit the NP. If the patient is harmed by the NP’s error and files a lawsuit based on malpractice, the NP also has a legal problem.

All NPs face certain risks associated with practice:
- Risk of making a clinical error
- Risk of being sued for malpractice when there was no clinical error
- Risk of public perception that the NP is a poor-quality provider
- Risk of exceeding legal scope of practice
- Risk of breaching patient confidentiality and/or privacy
- Risk of failing to inform patients fully about treatment and to get informed consent to treat
- Risk of failing to disclose information that patients need to get follow-up
- Risk of poor quality ratings
- Risk of disciplinary action
- Risk of being accused of Medicare fraud for upcoding a patient visit
- Risk of business failure as a result of undercoding patient visits
- Risk of being accused of prescribing or dispensing controlled drugs inappropriately

Whether any of these risks becomes an actual problem is largely up to the NP.

**Risk of Making a Clinical Error**
Medical professionals who have been sued report that the experience soured their attitudes toward their profession. NPs are rarely sued. Nevertheless, a lawsuit, even a lawsuit where the NP is not found
to be liable, is a devastating personal experience. Therefore, every NP should incorporate into his or her practice an awareness of how to avoid malpractice.

NPs will maintain their positive attitudes toward their profession by practicing litigation avoidance techniques, just as they would advocate preventive medicine and healthcare maintenance to their patients. Avoidance measures include exercising caution about establishing patient–provider relationships and, when a patient–provider relationship has been established, practicing consistently in conjunction with the accepted standard of care for NPs.

**What Is Malpractice?**

*Malpractice* is a failure of professional skill that results in injury, loss, or damage. A claim of malpractice requires that a patient/plaintiff prove the following:

1. The existence of a client–professional relationship—a “duty of care.”
2. Behavior below the appropriate standard of care for professionals dealing in like circumstances.
3. A causal link between the practitioner’s failure to conform to treatment standards and harm to the patient.

4. Actual injury to the patient.

More detailed information on medical malpractice is provided elsewhere in the text.

Existence of a Professional Relationship

A patient–provider relationship is established when a patient arrives at an NP’s office for a visit, when an NP undertakes the care of a hospitalized patient, or when an NP makes a home visit to a patient. However, patient–provider relationships also can arise in other less obvious ways, including the following:

- Over the telephone
- At a social gathering
- By supervising another’s treatment
- By providing sample medication
- By giving advice or opinions to family or friends

When Is a Person a “Patient”? 

Consider the following example: NP Jones receives a message to call Nurse Smith at home. Nurse Smith is a former colleague of NP Jones, and Jones remembers Smith as a very talented and competent
nurse. Smith is calling about a personal health matter. Smith’s son, James, age 6, has an earache. James has had several earaches in the past, all caused by infections, all cleared by amoxicillin. James is otherwise completely healthy, reports Smith.

Smith is working the evening shift, and James is in first grade all day. Smith does not have time to see James’s pediatrician until the end of the month, 2 weeks away. Nor does Smith want to pay the $25 copay to see the pediatrician. NP Jones remembers that he met James once at a picnic, but he has never seen James in the office. Smith recalls that she has always respected NP Jones’s judgment. Smith asks NP Jones, a family NP, to prescribe amoxicillin for James. Smith is asking a favor because she and NP Jones both know that Smith’s HMO insurance will not reimburse NP Jones for an office visit.

Is 6-year-old James NP Jones’s patient? If NP Jones calls in a prescription for James, the answer is yes.

**Managing Risk by Limiting Patient Relationships**
If NP Jones gives any advice to Nurse Smith or prescribes any medication to James, NP Jones has taken on a professional relationship with James, and James is now NP Jones’s patient. NP Jones will then be liable for any breach in the standard of care that leads to an injury to James. It does not matter that James is the patient of another provider. It does not matter that NP Jones will receive no compensation for treating James. It does not matter that the interaction occurs solely over the telephone.

NP Jones, to protect himself (manage his risk), should either (1) politely refuse to give advice, other than that Smith should call James’s pediatrician, or (2) require Smith to bring James to NP Jones’s office to go through the usual new patient evaluation before Jones prescribes an antibiotic or otherwise treats James. NP Jones should then follow up with James as NP Jones would with any of his patients.

For 95 out of 100 times that NP Jones is presented with a situation like this, NP Jones could proceed to treat the child over the telephone with no ill effects to the child or to NP Jones’s malpractice history. However, NP Jones will be liable in court for the 5% of cases where (1) the mother makes an erroneous diagnosis, (2) the mother does not know that the organism in the child’s ear is resistant to the
antibiotic used in the past, or (3) there is some other problem that NP Jones would have discovered with a careful history and physical examination.

In short, NPs should say no to all requests they receive for care that skirt the normal, safe evaluation process. The lesson of this case may seem elementary to experienced NPs. However, it is included because the pressure is great to deliver care to people who “just want a little advice” but are not “patients.” It is easy for an NP to forget that she or he bears professional responsibility for any healthcare advice given.

What Is the Standard of Care for NPs?

The standard of care in any clinical situation is discovered by answering the question, What reasonable and ordinary care, skill, and diligence would be given by practitioners in good standing, in the same geographic area, in the same general type of practice in similar cases?

NPs are held to the standard of care of the reasonable and diligent NP. Is this the same standard that pertains to physicians? It may be. If the NP is performing primary care services, for example, the standard of care for an NP and for a
physician performing those services will be the same standard.

Consider the example of *Fein v. Kaiser Permanente* (discussed in detail elsewhere in the text). The *Fein* case is a good illustration of a missed diagnosis. In that case, Mr. Fein, a middle-aged attorney, called a Kaiser clinic at midday complaining of chest pains. He got a 4:00 p.m. appointment, at which time he was evaluated by an NP who incorrectly diagnosed musculoskeletal pain. Mr. Fein was having a myocardial infarction. Later in the evening, Mr. Fein was evaluated by a physician, who also incorrectly diagnosed Mr. Fein’s chest pain. It was not until Mr. Fein’s third visit that an electrocardiogram was done.

The NP easily could have ruled out myocardial infarction through an electrocardiogram at the first visit. That would be risk management. A prudent NP faced with a middle-aged male patient with chest pain would rule out myocardial infarction before diagnosing musculoskeletal pain. In this case, the NP and physician shared the same standard of care.

**How Does an NP Keep Up with the Standard of Care?**
Sources of information about standards of care for any specific disease or healthcare maintenance effort include:

- Internet articles
- Newsletters and listserves
- Textbooks and reference books
- Professional journals
- Respected colleagues
- Continuing education presentations
- Government agency–generated guidelines, such as Agency for Healthcare Research and Quality guidelines
- Professional association guidelines

An NP who wishes to avoid breaching the standard of care will consult current books and journals on a day-to-day basis, attend continuing education presentations regularly, refer patients to specialists when necessary, and seek consultation from attending or consulting physicians or from other NPs when necessary.

**Risk of Being Sued for Malpractice When There Was No Clinical Error**

Some patients sue healthcare providers when there was a poor outcome but no actual malpractice on the part of the provider. Whether a provider has, in fact, fulfilled the elements of malpractice is not
determined until there is a trial on the matter or the matter is settled out of court.

NPs who have the opportunity to defuse a potential lawsuit through extra time spent with a dissatisfied patient should do so, even if they know that any threatened lawsuit is ultimately without merit. Therefore, risk management efforts aimed at avoiding lawsuits include keeping patients satisfied and appeasing dissatisfied patients. Patients are annoyed by long waits for appointments, long waits in the office waiting room, impersonal treatment, and constant busy signals when trying to call the office. Keeping in mind the estimate that 90% of dissatisfied patients will not complain, it is wise to pay attention to patient complaints and to attempt to resolve problems with patients.

**Risk of Public Perception That the Individual NP Is a Poor-Quality Provider**

The risk of being perceived as a poor-quality provider is perhaps more of a business risk than a legal risk. How could an NP get a reputation as a poor provider? Like any other professional, an NP can get a poor reputation by failing to follow up with clients; by being inattentive, late, forgetful, or sloppy in appearance, demeanor, language, or intellect; by
being unreliable; or by being unable to make a decision.

**Risk of Breaching Patient Confidentiality**

Patients have a right to confidentiality. Breach of privacy is an intentional tort and can be the basis for a lawsuit by a patient. Breach of privacy also can be malpractice, the basis for a disciplinary action by a state’s board of nursing, and a violation of state and federal law. And, under federal regulations, a patient who feels that his or her NP has violated his or her privacy rights can complain to the U.S. Office of Civil Rights. The Office may investigate, and, if an NP has not complied with the government’s recommendations aimed at protecting patient privacy, the government may fine the NP and the NP’s organization.

NPs can breach a patient’s confidentiality in the following ways:

- Talking about a patient within earshot of others
- Releasing medical information about a patient without prior written permission
- Leaving a telephone message on a patient’s answering machine
Discussing a patient’s condition with family members
Leaving patient records within view
Discarding unshredded duplicate records
Giving a patient’s name and address to a vendor
Accessing a patient’s medical record unnecessarily, for curiosity purposes
Leaving a laptop containing patient information on a subway train
Faxing patient data to the wrong number, by mistake

It is unusual for patients to sue for breach of confidentiality and it may be difficult for patients to prove. However, patient word of mouth about perceived breaches of confidentiality can harm community perception of a medical practice or provider. Therefore, NPs should seek private places to discuss patients, arrange for discarded records to be shredded, keep records out of view of others, and decline to discuss patient conditions or send written documents on a patient unless the NP has the patient’s written permission. An example of an authorization form to use when it is necessary to disclose information about patients to third parties for reasons other than patient treatment, payment, or healthcare operations is given in Exhibit 8-1.
Authorization Form

This form allows a patient to authorize release of protected healthcare information for specified purposes other than treatment, payment, and operations, or to disclose protected healthcare information to a specified third party.

I authorize [Name of provider and/or class of person authorized to make the use or disclosure] to release my:

- Name
- Address
- Telephone number
- Email address
- Social Security number
- Insurance policy information
- Diagnosis or health status
- Laboratory tests or results
- X-rays
- Immunization record
- Physical exam results
or

☐ Other information about my health status, described as follows:

To: [Name of authorized recipients or class of recipients to which information may be released]

via:

☐ Fax to [Name and number]

☐ Mail to [Name and address]

☐ Telephone to [Name and telephone number]

☐ Pick up in person

For the purposes of:

____________________________________________________________________________________

____________________________________________________________________________________

This authorization is effective on the date signed and continues until:

☐ [Date]

I understand the following:
a. If I refuse to authorize release of my health information, [Name of practice and provider] may not refuse to treat me.
b. I may revoke this authorization at any time by notifying [Name and contact information of privacy officer].
c. The information disclosed pursuant to this authorization may be redisclosed by the recipient and therefore may be outside the protection of federal rules on privacy.
d. The healthcare provider named here: □ will □ will not receive remuneration for disclosing information about me.

Signature __________________
Printed name __________________
Date __________________

Risk of Violating a Patient’s Right to Informed Consent
A patient has a right to consent to the care being given and a right to refuse care that is offered. An
NP has a legal responsibility to give a patient enough information about the risks and benefits of the care being offered that the patient can make an informed decision about accepting the care.

Informed consent involves disclosure of material risks of care and requires that a patient be competent to understand the risks and make a judgment about accepting care. The doctrine of informed consent requires that there be no coercion in getting a patient to consent to care. The law of informed consent is physician oriented, but the doctrine can be expected to be upheld when an NP is the caregiver.

The doctrine of informed consent arose from a societal desire to discourage persons from unauthorized touching of others. The predisposition against nonconsensual touching expanded when applied to the practice of medicine. In medicine, the requirement is that a physician must inform a patient about what is to be done and obtain the patient’s consent before treating. Even though the doctrine of informed consent is grounded in the law of battery, the objective of the courts in applying the doctrine of informed consent has been more involved than the simple avoidance of one person’s unauthorized touching of another. The majority of courts have
adopted a self-determination rationale for informed consent. That is, a person has a right to determine what shall be done with his or her body.¹

Many cases where patients have complained that their right to informed consent was violated involved surgery. Of course, surgery is only one of many possible treatments, and physicians are only one of many possible healthcare providers. There are many decisions to be made when a person seeks medical attention, most of which are less dramatic than surgery. For example, prescription drugs have been known to have side effects not discovered until years after the drugs were in common use. Even when a treatment has been used for years with relatively few complications, patients subjected to treatment may want to know that they are taking a risk and that there may be side effects.

An NP who is trying to minimize personal risk and risk to a patient will give as much information as possible to a patient contemplating any therapy. How much information does a patient need? Enough to formulate a reasonable decision.

If an NP failed to get informed consent from a patient before treating the patient, the patient could sue the NP, basing a suit on battery or on
negligence. A patient who sued an NP for battery would claim that the patient had not authorized the NP to touch the patient. A patient who sued on the basis of negligence would claim that the NP had not given the patient enough information to consent, in an informed way, to the treatment. In either case, a patient could win monetary damages from the NP.

Does an NP need to get consent for everything? It is well established that before a surgeon performs surgery, he or she must obtain the informed consent of the patient. It is less clear whether an NP must get informed consent before prescribing medication; whether minor but invasive procedures, such as blood transfusion, the starting of intravenous lines, and office incision and drainage, require informed consent; and whether noninvasive treatments carrying some risk, such as office psychotherapy, massage, or even an examination, require informed consent.

At least 25 states have legislation regarding informed consent. An example of an informed-consent statute, one that is oriented toward the physician, is New York’s. That law defines lack of informed consent as:
Failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonable, foreseeable risks and benefits involved as a reasonable medical, dental, or podiatric practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation.

_Citation:_ N.Y. P U B. H E A L T H L A W § 2805-d.

The law limits the right of action to nonemergent therapies and diagnostic procedures that involve invasion or disruption of the integrity of the body. The statute conforms with New York’s case law, which limits the cause of action to procedures that are invasive. The law lists defenses.

Another example of a statute addressing informed consent is Washington’s (Wash. Rev. Stat. Ann. Code § 7.70.050). That law states the elements of informed consent as (1) failure to inform regarding a material fact, (2) patient consented without being aware of the facts, (3) a reasonably prudent patient
would not have consented if the information had been adequately conveyed, and (4) injury to the patient.

All states have case law requiring that physicians inform patients of the risks and benefits of surgery and obtain patient consent in writing before doing surgery.

Other courts, while not holding that the doctrine of informed consent applies to nonsurgical treatments, have stated in an aside (dictum) that the term “treatment” can be broadly construed [*Pratt v. University of Minn. Affiliated Hosps. and Clinics*, 414 N.W.2d 399 (Minn. Ct. App. 1987)]. The state that defines treatment most broadly is Minnesota. According to the Minnesota Supreme Court, bed rest, when combined with special instructions, would constitute treatment [*Madsen v. Park Nicollet Med. Ctr.*, 431 N.W.2d 855 (Minn. 1988)]. At the opposite extreme is New York, where the need for informed consent is limited to invasive procedures [*Karlsons v. Guerinot*, 57 A.D.2d 73, 394 N.Y.S.2d 933 (App. Div. 1977)].

At least one court has declined to find the need for informed consent in a common, minor, invasive procedure. Informed consent was not applicable to the giving of a flu shot in a Louisiana medical clinic. The court stated that “medical or surgical procedure” did not extend to a flu shot and that to hold otherwise would lead to results in the day-to-day practice of medicine never intended by the legislature [*Novak v. Texada*, *Miller, Masterson and Davis Med. Clinic*, 514 So. 2d 524, writ denied, 515 So. 2d 807 (La. 1987)]. That one court found bed rest a treatment but another found an injection not a
medical or surgical procedure demonstrates the inconsistency of viewpoint among jurisdictions.

The Minnesota Supreme Court, going a step further than most other jurisdictions, stated, “[We] believe there may be some nontreatment situations where the doctrine should be applicable” [Pratt v. University of Minn. Affiliated Hosps . and Clinics, 414 N.W.2d 399 (Minn. Ct. App. 1987)]. In Pratt, a case about genetic counseling, a plaintiff couple asserted that physicians had been negligent in not disclosing the risk of the couple’s encountering a particular genetic abnormality in future children. The physicians, after interviewing the couple and obtaining the tests available, had rejected one possible diagnosis, autosomal recessive disorder, as highly unlikely. Therefore, they did not disclose to the parents the risks of that condition. A subsequent child of the couple was born with autosomal recessive disorder, the diagnosis thought unlikely by the physicians. The plaintiffs asked the Minnesota court to apply to genetic counseling a variation on the doctrine of informed consent [Pratt v. University of Minn. Affiliated Hosps . and Clinics, 414 N.W.2d 399 (Minn. Ct. App. 1987)]. Because diagnostic advice and counseling, not treatment, was the medical service involved, the term negligent
nondisclosure was used. Negligent nondisclosure is discussed more fully in the next section.

The court held that the mere diagnosis of a condition, where all appropriate tests have been performed, does not give rise to a duty to disclose risks inherent in conditions not diagnosed [Pratt v. University of Minn. Affiliated Hosps. and Clinics, 414 N.W.2d 399 (Minn. Ct. App. 1987)]. While negligent nondisclosure did not apply in this case, the court stated that the doctrine could be applicable in some other nontreatment situations.

In summary, there is wide disparity among the states regarding how the doctrine of informed consent may be applied. At one end of the continuum, informed consent is needed only for invasive procedures. At the other end, it is needed for counseling.

In Canterbury v. Spence [464 F.2d 777 (D.C. Cir. 1972)] [See also Sard v. Hardy (281 Md. 432, 379 A.2d 1014)], the U.S. Court of Appeals for the District of Columbia Circuit gave some general advice to physicians that holds true today and can be applied to NPs. The court declined to adopt a standard of full disclosure, saying that it is prohibitive and unrealistic to expect physicians to
discuss every risk of a proposed treatment and that such full information generally is unnecessary from a patient’s viewpoint. However, the court listed physicians’ responsibilities regarding disclosure:

1. Communicate information to the patient when the exigencies of reasonable care call for it.
2. Alert the patient to symptoms of bodily abnormality.
3. Inform the patient when the ailment does not respond to the physician’s ministrations.
4. Instruct the patient about any limitations to be observed for his or her own welfare.
5. Inform the patient about precautionary therapy that he or she should seek in the future.
6. Advise the patient of the need for or desirability of any alternative treatments promising greater benefit than that being pursued.
7. Advise the patient regarding risks to his or her well-being that the contemplated therapy may involve.

Citation: Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972).
Many practices cover the risk of a claim of battery by having each patient sign a consent to an examination at the time of registration. Most practices have informed-consent policies that address invasive procedures, such as endometrial biopsy, cervical biopsy, and incision and drainage.

NPs who want to avoid the risk of violating the informed-consent doctrine should do the following:

- Give patients information on risks, benefits, and alternatives to any invasive procedure, and obtain written consent for any procedure.
- Find out what state law requires in the way of informed consent for specific tests, treatments, and procedures.
- Give patients information on the risks, benefits, and alternatives to any treatment, including prescription medications, and ask for their agreement to the treatment.
- Document that information about the risks, benefits, and alternatives to the treatment has been given to the patient and that the patient agrees to the treatment.

Does an NP Need to Get Consent in Writing?

Consent to surgery must be in writing. Consent for invasive procedures that could be considered
surgery—endometrial biopsy, for example—should also be in writing. If state law requires consent for specific testing, it must be in writing. In general, however, consent to medical treatment need not be in writing.

**Special Cases**

**Emergency Situations**
In an emergency, care may be given to save a patient’s life, even if consent cannot be obtained prior to treatment.

**Incompetency**
A patient who is unconscious or intellectually or developmentally disabled; who has been judged insane; who cannot read, write, or hear; or who is under the influence of sedative drugs or alcohol is not competent to give consent. With the exception of an emergency situation, NPs should avoid treating such patients unless a parent or a court-appointed guardian is available to give consent.

**Minors**
Minor children cannot consent to treatment. Parental consent is necessary.

**Risk of Negligent Nondisclosure**
The doctrine of negligent nondisclosure emerged when a physician found an abnormality but failed to sufficiently alert the patient. For example, in Cornfeldt v. Tongen [262 N.W.2d 684 (Minn. 1977)], a physician failed to inform a patient of abnormalities in blood testing prior to surgery.

The Minnesota Supreme Court defined the elements of negligent nondisclosure as (1) nondisclosure of a risk inherent in the treatment, (2) harm materialized from that risk, and (3) proximate causation. The elements of lack of informed consent are the same. The terms lack of informed consent and negligent nondisclosure refer to the same concept, though they are applicable in different situations. Consent is applicable when a treatment is proposed. Nondisclosure is applicable when an omission of information leads to an injury.

Under the doctrine of negligent nondisclosure, a physician (or an NP), having examined a patient and having found an abnormality, has a duty to inform the patient of the abnormality so that the patient can choose whether to submit to further tests [Gates v. Jensen, 92 Wash. 2d 246, 595 P.2d (1979); Canterbury v. Spence, 464 F.2d 777 (D.C. Cir. 1972)]. All facts must be disclosed that the doctor (or, by inference, the NP) knows or should
know for the patient to make a decision. Some examples include *Truman v. Thomas*, 165 Cal. Rptr. 308, 611 P.2d 902 (Cal. 1980), in which a patient sued a physician for failing to disclose the danger of refusing a Pap smear, and *Lauderdale v. United States*, 666 F. Supp. 1511 (D. Ala. 1987), in which a physician was found liable when he did not inform a patient of a heart problem, the seriousness of the problem, and the necessity for a return visit.

In *Gates v. Jensen*, a physician discovered an increased pressure in a patient’s eyes. This suggested glaucoma, a treatable eye disease. The physician failed to inform the patient of the abnormality and of diagnostic procedures that could be undertaken to determine the significance of the abnormality. This resulted in a delay in the diagnosis and treatment of the glaucoma. By the time glaucoma was diagnosed, the patient was functionally blind. The Supreme Court of Washington found that the physician had a duty of disclosure. The court held that the doctrine of informed consent required that the ophthalmologist inform the patient of an abnormality discovered during a routine examination and of diagnostic procedures that could be taken to determine the significance of that abnormality. The court reasoned
that a physician has a fiduciary duty to inform a patient of abnormalities in his or her body.\(^6\)

In *Truman v. Thomas*, the issue was whether a physician should have disclosed to his patient the risks of refusing a test. There, a physician had advised his patient to have a Pap smear, a test that detects the presence of cervical cancer, but did not inform her of the risks of refusing the test. She refused to have it. As a result, cancer of the cervix went undiscovered until it had become disseminated. The patient died at the age of 30. The Supreme Court of California held that the trial judge should have given an instruction to the jury that would have allowed the jury to consider whether the physician breached a duty by not disclosing to the patient the danger of failing to undergo a Pap smear.

From a healthcare provider’s point of view, there are few guidelines. To give too much detail could be uneconomical. To give too little could be negligent. From a patient’s point of view, a requirement that more information be given can only be beneficial.

**Right of Patients to Refuse Treatment**
Patients may refuse treatment. NPs caring for patients who refuse treatment that the NP believes is necessary should inform such patients of the risks of refusing treatment. After that, it is the patient’s right to decide. NPs should document that they have explained the risks, benefits, and alternatives of treatment and the risks of refusing treatment and that the patient nevertheless refuses it.

**Risk of Poor-Quality Ratings**
Increasingly, consumer-oriented groups and Medicare are compiling and reporting data on performance of healthcare providers, using various measures. Consumer-oriented groups collect data from health plans, and health plans collect the data from medical practices. The National Committee on Quality Assurance’s HEDIS (Health Plan Employer Data and Information Set) is currently the most commonly applied performance criterion among health plans. HEDIS data are gathered from patient surveys, patient charts, and billing forms. For more information or current HEDIS measures, visit the website ([http://www.ncqa.org](http://www.ncqa.org)). Medicare collects quality data through its Physician Quality Reporting Initiative (PQRI) and, more recently, Merit-Based Incentive Payment System (MIPS). For more information on PQRI or MIPS, visit the Centers for

An NP who wants to avoid the risk of poor-quality ratings should:

- Understand what performance measures are currently being used
- Develop personal or practicewide systems for complying with performance guidelines and monitoring his or her performance
- Request and obtain feedback on performance

**Risk of Disciplinary Action**
A state board of nursing approves an NP’s right to practice in a state. A board of nursing can suspend or revoke an NP’s license.

A court cannot revoke an NP’s license. A court can find against an NP in a malpractice lawsuit and direct an NP to pay an injured patient monetary damages, however. If, on the basis of what a judge hears in a case, the judge believes an NP to be grossly negligent, the judge may report the nurse to the board of nursing. *Gross negligence* is indifference to duty or the intentional failure to perform a manifest duty in reckless disregard of the consequences as affecting the life of another.
A board of nursing will respond not only to reports of gross nursing negligence but also to reports of impairment, fraud, or criminal activity by nurses. Impairment could be reported by a patient, coworker, or supervisor, based on her or his observation of a nurse. Fraud might include falsifying the nurse's application to the board, falsifying medical records, or documenting that a patient has been seen when the patient has not. A nurse convicted of a felony can expect to be investigated by the board of nursing.

In general, the disciplinary process is as follows:

1. The NP receives a letter stating that he or she is being investigated by the board and requesting that the NP call the board to arrange a meeting.
2. The NP meets with an investigator. The investigator will produce records or other evidence of questionable care given by the NP and ask the NP to respond. The NP may explain why the NP conducted the care or documented the care as he or she did.
3. The investigator will gather information from other sources. The investigator may talk with auditors, colleagues, patients, or administrators.
4. The investigator will recommend to the board that the investigation be dropped or will recommend a hearing.

5. An administrative hearing, resembling a trial, will be held. The NP should be represented by an attorney. The board of nursing will be represented by a state attorney. Evidence may be presented. Witnesses may testify. Often, the board will give the nurse the option of a prehearing settlement conference. In that case, the nurse, his or her attorney, some board members, and some board staff meet in a less formal setting and discuss the matter. The board representatives may recommend a disposition of the matter without an evidentiary hearing.

6. A hearing officer (or board member present at the prehearing settlement conference) will make a recommendation to the board.

7. The board will decide to drop the matter or discipline the nurse.

8. Discipline may include probation, suspension of a license, or revocation of a license.

9. After the passage of a specified time period, the nurse whose license is revoked may reapply for licensure.
Only a small percentage of registered nurses have been subject to disciplinary action by boards of nursing. The percentage of NPs subject to disciplinary action is probably even smaller. However, NPs are subject to discipline, and it is not unusual for an NP to be called before the board of nursing for an investigatory meeting. For example, an NP might be reported to the board of nursing after an audit of a hospital or nursing home turned up irregularities.

An NP who receives a notice of investigation should be worried. Even if an investigator characterizes the meeting as nonadversarial and states that its purpose is strictly information gathering, an investigation is in fact adversarial and an NP has much to lose. NPs should know that state auditors of nursing homes are not NPs and may not be experienced in evaluating the work of NPs. Furthermore, board of nursing investigators usually are not NPs, though they are probably registered nurses (RNs). An RN investigator may ask such questions as “This EKG (electrocardiogram) reading says ‘abnormal EKG.’ Why did you not call in a cardiologist or send the patient to the emergency room?” The answer may well be “That abnormality is a left axis deviation that was not clinically significant for that patient at that time. A cardiology
consult or an emergency room visit was not clinically indicated.” That response may end the inquiry about the abnormal EKG. The RN investigator may not know the nuances of EKG interpretation and may find that answer satisfactory. An NP who can explain all of his or her actions probably will find that the investigation ends with the meeting. However, an NP who is distraught by the nature of the investigation may not give clear explanations. An NP under the pressure and emotional upset of investigatory questioning may not be as assertive in defending his or her actions as is legally prudent.

An NP who receives a letter notifying him or her of an investigation by the board of nursing should retain an attorney immediately. The attorney should represent the NP at the initial meeting with the investigator for the board of nursing. Investigators may tell NPs that an attorney is not necessary. Investigators may also tell NPs that attorneys are not allowed at the meeting. Nevertheless, the NP should engage an attorney, and the attorney can communicate with the investigator about attending the meeting. Attorneys are comfortable with adversarial interactions, experienced in advocating for clients, and not likely to dissolve into tears when an investigator questions the NP’s professional
competency. Furthermore, an attorney will see that an NP’s due process rights are protected through the investigation and hearing.

**Risk of Medicare Fraud**

In the past 15 years, the U.S. Justice Department has increased its investigative efforts into healthcare fraud and abuse. The level of fraudulent billing is such that an estimated 7–8% of total healthcare spending goes not for care given but rather for care not given.\(^7\)

NPs are responsible for ensuring that the billing for their services matches the level of care given and that their documentation matches the level of care billed. *Upcoding* is billing for a higher level of visit than actually was conducted. Upcoding is healthcare fraud.

Each Current Procedural Terminology (CPT) code has corresponding levels of required history taking, physical examination, and medical decision making, all of which must be supported in an NP’s medical record documentation. For example, if an NP meets all of the criteria for a CPT 99214 visit and bills for a 99214 visit but documents only the criteria for a 99213 visit, the NP is at risk of being charged with Medicare fraud. Fraud is intentional deception.
Billing a higher code than is supported by documentation may be unintentional. However, NPs are expected to know how to bill correctly. Ignorance is a poor defense. Furthermore, if a provider pleads ignorance but auditors find that more errors were made in overcoding than undercoding visits, a court will find that the upcoding was intentional. On the other hand, providers will not want to undercode. Undercoding will lead to low revenues for a practice.

Consequences of selecting an inappropriate code are Medicare or Medicaid audit failure, loss of Medicare or Medicaid provider status, a fine, and loss or restriction of the NP’s license by the board of nursing. Obviously, the consequences also can include loss of one’s job.

CMS and the American Medical Association have agreed on a set of documentation guidelines. These guidelines went into effect in July 1998. Revisions have been proposed since then, but as of the publication of this text, clinicians should abide by the 1995 or 1997 guidelines, whichever the clinician finds to be most useful. The guidelines appear in Appendix 4-A.

Business Risk Management
An NP who starts a business risks business failure. If the NP has partners or fellow directors or stockholders in a corporation, the NP also risks failure of those relationships.

Who Is the Boss?
Consider the following example: Nurse Practitioner Able and Nurse Practitioner Best have agreed to go into practice together. Able is an OB-GYN NP, and Best is a family NP. They are both very experienced. They have known each other for 5 years. They have never worked together, but each knows that the other is well respected in the community. They have carefully planned the business and have decided to be “equal partners.”

A friend of Best told Best that she should have a written agreement with Able. Best called Attorney Clodd, who told Best that he charged $350 an hour and that a partnership agreement usually ran about $900. Clodd also told Best that he would represent only Best and that Able should have her own attorney in the partnership-forming process. Able and Best wanted to forgo the expenses of attorneys at this stage. They decided not to draw up a partnership agreement.
The practice opened. Able and Best had no problem choosing the location for the practice, the furniture, or the equipment. They agreed on a receptionist.

After 3 months, Best noticed that half of Able’s patients were without insurance and that many did not pay for service at the time of service and owed the practice money. Best’s patients had insurance for the most part. Furthermore, the lab was billing the practice for Pap smears and other expensive gynecologic tests, and the lab’s bills were mounting. Best had been telling her patients that if there was no insurance to cover the visit and any necessary laboratory work, the patient, not the practice, was responsible for the office visit and lab charges.

Best told Able about the bills and the accounts receivable for Able’s patients. Able, who saw her patient roster growing, did not want to offend patients by pressing about the bills. Best wanted to press for payment those patients with outstanding bills. Best’s husband was tiring of Best being without a paycheck and was pressuring Best to be a better businessperson.

Who is the boss in this situation? Able and Best did not establish a method of resolving disagreements between them. Therefore, no one is the boss, and
they could argue about this issue, or other issues, for years.

**How to Avoid a Broken Partnership**

When a practitioner starts a business alone, there is no confusion about who makes the administrative and business decisions. Whenever more than one person is involved, however, there will be more than one opinion on how the business should operate. Often, decisions must be made for which there is no “right” or “wrong” answer. Magazines on medical practice management and the civil courts are full of examples of partnerships gone sour. Often, the reasons for the breakup are differences of opinion on how practice collections are made and how practice money is spent. To avoid the risk of deadlocked disagreement, which can lead to hurt feelings, which in turn can lead to “wanting out,” it is wise for the members of the group to agree on a decision-making process from the outset.

Any private practice should have one of the following forms of business: sole proprietorship, partnership, or corporation. If the business is a corporation, the corporation’s bylaws (or operating agreement, in the case of a limited liability corporation) describe the chain of command within
the company. If the business is a partnership, the partners in the business should have an agreement between them specifying the decision-making process. Partners who fail to specify, early in the process of forming the practice, who is to make what decisions and how a deadlock will be resolved will be facing a short-lived association.

Drawing up an administrative chart should be one of the first tasks in the planning process. At minimum, all principal practitioners should agree to the administrative structure. It is prudent to consult an attorney.

**Dealing with High-Risk Patients**

Certain patient characteristics should alert an NP to be especially aware of risk management strategies. These characteristics are multisystem failure, low intelligence, polypharmacy, noncompliant behavior, positive review of systems, substance abuse, and litigiousness.

**Multisystem Failure**

Refer or work closely with a consultant when caring for patients with multisystem failure. The risk is failure to refer when the standard of care would call for referral.
**Intellectual Disability**
Have a guardian present when counseling or teaching a patient with intellectual disability. The risk is failure to get informed consent to treatment. A patient who does not have the intellectual capability to process information and make decisions about his or her own care cannot be assumed to have consented to treatment.

**Polypharmacy**
When patients are on many medications, list the medications, side effects, cautions, and dosing instructions for the patient, or coordinate with a pharmacist who will run computer printouts with the information. Review the dosing schedule with the patient at every visit. Ascertain that the patient can read—that the patient is literate and has adequate eyesight.

**Noncompliant Patients**
Document attempts and strategies for increasing compliance in the noncompliant patient. Document the patient’s verbal responses to the NP’s questions about why the patient has not taken the recommended medication, controlled the diet, or changed the dressings.

**Positive Review of Systems**
When a patient has a generally positive review of systems, consider expanding the patient’s problem list even further to include somatization, need for social support, inability to cope with life’s pressures, and dependency issues. Consider repeating the review of systems on another visit to see whether the complaints persist. If so, an NP should be prepared to dissect each complaint, taking the more risky complaints first. Whether the problem list is long or short, there is no difference in the standard of care expected of an NP.

**Substance Abuse**
Do not be lured into becoming a source for a patient who is abusing substances. Patients have sued their healthcare providers for contributing to their substance abuse by prescribing medication.

**Litigiousness**
Patients who bring up their ongoing lawsuits against another provider can be expected to repeat the performance by suing their current provider.

**Risk of Being Accused of Prescribing or Dispensing Controlled Drugs Inappropriately**
NPs have been prosecuted, by both boards of nursing and district attorneys, for prescribing and/or
dispensing controlled drugs when medical necessity has not been documented. For example, a family nurse practitioner was in the disciplinary process with a board of nursing for issuing 8,798 prescriptions for controlled substances to patients in an 18-month period, while failing to individualize treatment; follow minimum standards in pain management; exhaust low-risk, evidence-based treatments before resorting to high-risk treatments; develop a treatment plan corresponding to assessment; and appropriately monitor patients for “aberrant and/or drug-seeking behavior.” It was especially upsetting that he routinely prescribed hydrocodone, a muscle relaxer, and an anxiolytic in the same doses, strengths, and quantities. That trio of medications is particularly popular on the streets.

To lower risk of prosecution:

- Never prescribe hydrocodone, alprazolam, and carisoprodol together.
- If prescribing controlled drugs, follow at least one current guideline from an agency or association. Guidelines typically say:
  - Perform and document an evaluation that justifies the prescription before prescribing a drug.
- Check prescription drug database before prescribing
- Contract with patient
- Order urine screens at least every 6 months, to determine what the patient is taking or not taking
- Evaluate progress and if the patient is not making progress on his or her treatment goals, discontinue the drug.

- Check state law to determine whether prescribers must check the state’s Prescription Drug Monitoring Program database before prescribing an opioid. At least 16 states have such a requirement. Those states include Connecticut, Kentucky, Maryland, Massachusetts, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee, West Virginia, and Wisconsin.

**Electronic Medical Records: 18 Ways to Reduce Legal Risks**

Recent presidents have heralded electronic medical records (EMRs) as a way to avoid medical mistakes, reduce costs, and improve care. EMRs do offer safeguards and efficiencies. However, the technology brings a new set of risks to the table. And EMRs don’t eliminate a significant set of risks
that are present whether one uses the pen or the keyboard.

Benefits include immediate access to records, improved legibility, standardized documentation when using templates, built-in safety mechanisms, and clinical decision support. There is less likelihood that clinicians will be faced with the risky business of conducting a visit without a patient record; that pharmacists, auditors, and other clinicians will be hampered by sloppy handwriting; or that clinicians will prescribe a medication to which the patient is allergic.

On the other hand, EMRs may generate new types of calamities. For example, some clinicians will be sloppy clickers just as some clinicians have bad penmanship. Malpractice defense may be hampered by an overabundance of meaningless documentation generated by use of templates. Insurance auditors may doubt the veracity of documentation when, because of thoughtless use of templates, 15 of 17 records they requested look essentially the same. And then there are the patient confidentiality (HIPAA) issues raised when clinicians take medical records out of the office on laptops or thumb drives.
A clinician who has knowledge of and pays attention to these risks can decrease the chances of EMR-related mishaps. This article describes the risks and offers suggestions for reducing the risks.

**Risks of Transition**

Let’s start with the transition from paper to digital. First, there is the issue of getting everyone on board. Early adopters have made the move, but others resist change. An example is the cancer center that decided to adopt electronic order entry and documentation. Some physicians obliged by quickly learning how to use the electronic ordering system but others, 9 months later, still refused to make the switch. The result is that the hospital was forced to maintain two systems for ordering and for recording data. This required nurses to know which physicians use EMR and which use paper, and to switch back and forth between paper and EMR. Not only did this take more time than when there is one record for each patient, but some orders for changes in chemotherapy dose or other important medications may have been overlooked, leading to a mishap for a patient.

Second, there is the problem of how to capture paper documents. Old records can be summarized in the electronic medical record, but this takes time
and attention to detail. The accuracy and completeness of the summary depends on the dedication of the clinician writing the summary. Copies of forms brought in by patients and filled out by practitioners are not going to get into the electronic medical record unless they are scanned. Again, this takes time, and a hurried clinician may just decide to put it off or forget it.

Third, there is the issue of complying with federal requirements so that a practice or facility can avail themselves of stimulus funds. On February 17, 2009, President Obama signed the Health Information Technology for Economic and Clinical Health (HITECH) Act, as part of the American Recovery and Reinvestment Act (ARRA). Under HITECH, the government has financially rewarded practices who purchased and made “meaningful use” of EMRs. Medicaid also has paid incentives to physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants who qualify.

**Components of EMRs**

Once an electronic medical system is up and running, there are other issues that are bound to arise. It is helpful to know what the risks are and where others have had mishaps. The components of an EMR are computerized provider order entry,
documentation of patient procedures, tracking, and billing. Ideally, all of these components interact and mesh with the others. And the components must be designed in such a way that patients’ privacy is protected.

The government’s objective is for eligible providers to be using computerized order entry for 100% of their orders. “Orders” include orders for medication, laboratory and diagnostic testing, procedures, immunizations, and referrals.

**Legal Pitfalls of EMRs**

Here is an example of a case where the safeguards of the EMR order entry didn’t work, because the clinician didn’t use them:

Case: A nephrologist ordered Prednisone 120 mg every other day for a patient in renal failure. A nurse sent the order to the pharmacy as Prednisone 120 mg every day. The EMR notified the nephrologist of the order, but the nephrologist signed off on his email notification of the prescription without reading it. The pharmacist’s computer system flagged the dose as too high. The pharmacist
called the nurse and the nurse confirmed the dosage regimen as daily. The nurse looked at her own documentation in the computer rather than the physician’s. The patient’s wife also questioned the nurse about the high dose but the nurse assured her it was correct. Nine days into the course of Prednisone the patient presented for a procedure complaining of tremors, esophageal burning, hiccups, stomach pain, and swallowing problems. The nurse reported these symptoms to the nephrologist by email, but the physician never looked at the email. Eight days later the patient called the physician, who was still unaware of the error, and complained he wasn’t feeling well. The physician told him to cut the dose to 10 mg a day. The patient arrived the next day with hypotension and tachycardia. He was admitted to the hospital with severe dehydration, gastrointestinal bleeding, and sepsis. He died 2 days later. On autopsy, the patient had angio-invasive gram-positive microorganisms, multiple
ulcers of the colon with full penetration through the muscular wall, peritonitis, and interstitial lung fibrosis. The family sued the nephrologist for prescribing a high dose of Prednisone, failure to monitor the patient’s progress, failure to supervise staff, and failure to give appropriate medical orders to stabilize and maintain patient’s deteriorating condition. The nurse and the practice also were named in the lawsuit.

Obviously, EMRs do not eradicate human error. A clinician may become overwhelmed with the volume of electronic notifications, and may ignore them. If clinicians don’t check messages, the EMR’s safeguards are worthless. And Clinician A may assume erroneously that Clinician B is aware of a problem, because an electronic notification has been sent, and so therefore Clinician A doesn’t personally follow up. This is compared with the old-fashioned method of communication, where in a face-to-face conversation, Clinician A would know whether or not Clinician B got a message.

Another risk arises when a clinician usually uses the e-prescribing function of an EMR, but, because the computer is temporarily unavailable or the clinician
is away from the computer, prescribes on paper. The prescription is not entered into the system, so not only are there no safeguards, but the next prescriber has no knowledge that the medication was ever prescribed.

These warnings are not meant to discourage NPs from embracing EMRs and e-prescribing. The majority of the approximately 7,000 deaths that occur each year in the United States due to medication errors are due to illegible handwriting, dose errors, and missed drug–drug or drug–allergy reactions. Most EMRs have the ability to detect drug–drug interactions and to warn the prescriber if the patient is known to be allergic to a medication being prescribed. It is a simple matter of heeding the warnings.

**Risk-Reduction Measures**

Risk-reduction measure #1: Establish personal and practice policies regarding electronic order entry. Be scrupulous about reading messages from the system. If email messages are too frequent, unsubscribe from unnecessary emails from other sources, or tailor the EMR such that it does not generate messages unless there is a serious error or warning.
Risk reduction measure #2: Develop systems and policies for dealing with orders that occur when the clinician is not at his work station or that occur when the system is temporarily down.

**Risks Inherent in Use of Templates**

Risk reduction measures #3 to #7 deal with use of templates in EMRs.

Risk reduction measure #3: Print out progress notes from time to time and evaluate them from the viewpoint of an auditor or expert witness. Are the records easy to evaluate? Do the records accurately portray what the clinician did for the patient?

A trainer for a Medicare Administrative Contractor recently stated the EMRs have led to “cookie cutter charting.” He cited the example of an audit that asked a physician’s office for 17 progress notes for specific patients on a specified date. When the charts were reviewed, 15 were essentially the same.

Auditors, expert witnesses who work for attorneys, investigators for licensing boards, and other clinicians find that lengthy notes generated by click-box templates don’t necessarily paint a picture as well as short free-text notes. It is so easy to click a
box. And once a clinician has clicked the box for “heart regular without murmur or S3,” the clinician cannot delete “S3” even if he or she did not actually evaluate the S3. So there is the possibility that a clinician may not have carefully assessed everything that is included in a template’s phrase.

Some clinicians may be tempted to use free text. However, if the EMR has the option of using free text, and if clinicians use free text, then the analyses that are possible with EMRs cannot be done, or cannot be done as readily. Clinicians must come to some save middle ground between using free text and producing voluminous, meaningless records via templates.

Here are some additional potential pitfalls of EMR documentation:

- An important finding can become buried in template charting.
- It is easy to inadvertently select the wrong patient from drag-down menus.
- If hospital staff rely on electronic capture of physiologic data, but there is a computer glitch or the leads fall off, there could be a long span of vital sign data that goes unrecorded.
Risk reduction measure #4: When printing out records for an auditor or for litigation, go over the printout carefully to be sure it includes relevant and necessary data from other tabs or screens.

Risk reduction measure #5: Highlight important aspects to template information.

Risk reduction measure #6: Beware of generic templates. These can yield undesirable documentation, such as noting, “Alert and oriented to person, place and time” for a newborn patient.

Risk reduction measure #7: Do not set up the system such that the template data automatically repopulates. For example, complaints should not automatically default, in subsequent visits, to “resolved.”

**Tracking Issues**
Missed diagnosis and failure to follow up are the two most common reasons why physicians and nurse practitioners are sued. One advantage of electronic medical records is the ability to track referrals and tests to determine whether they have been completed. Obviously, to be effective, the clinicians must use the tracking feature. For example, if a practice has an EMR with a tracking function, and a
clinician doesn’t use it, and a patient is injured because the clinician failed to note that a much-needed follow-up Pap smear was not done, a plaintiff’s attorney is going to ask “Why didn’t you use the safety functions of your EMR?”

The good news is that some EMRs have a feature that when a test is ordered the office note remains in an inbox until a result is received. Results come electronically into the inbox, with the note awaiting signature. The bad news is a hurried or careless clinician may be derelict in checking his inbox.

Risk reduction suggestion #8: Become familiar with the tracking features of the EMR. Decide which tracking feature will reduce risk for the clinician and the practice or facility. Commit to use those functions.

System Crashes
A clinician who fails to back up files and loses 600 patient records is going to have problems with payers when it comes time to audit, and, if the clinician is sued, will have no documentation for his attorney to use for defense.

Risk reduction measure #9: Back up. Check the backup method frequently. Clinicians may think they
are backing up but the hard drive may be faulty or network storage mechanism may be faulty.

Risk reduction measure #10: Install virus protection software on server and workstations.

**The Issue of Distraction**

Some clinicians who shy away from EMRs say that they don’t want their attention diverted from the patient to the computer screen and keyboard. If a clinician’s attentions truly are diverted, then this is a problem. However, clinicians certainly can work on their EMR just as clinicians have traditionally written their notes—while the patient is undressing or dressing. If the EMR generates questions for the clinician such that it is necessary to enter a patient’s response before moving on, perhaps the system can be set up so that the patient can answer questions before he sees the clinician.

Risk reduction measure #11: Eyes and ears need to remain attuned to the patient while the patient is in the room.

**Authorship Issues**

With some EMRs it is possible for one clinician’s entry to appear as another clinician’s entry, because the first clinician didn’t sign off the record or log out.
Obviously this is a problem. The first aspect of this problem is that a bill may be submitted under the first clinician’s name, while documentation appears to be written by the second clinician. A payer may demand a refund if such a medical record is submitted during an audit. The second aspect of this problem is that when a mishap occurs and a patient suffers an injury, both clinicians will want authorship of the medical record to be correct when the entry is printed for litigation defense purposes.

Risk reduction measure #12: Understand how the system records who is accessing and writing in the record. If there is a security protocol for logging in and out, it should be strict but not too time consuming. Features could include an automatic time-out after a period of inactivity. Clinicians may want to override automatic time-outs so that they can make entries later in the day. That may be reasonable, but note that if a record is never locked, clinicians can make changes up until the day the record is sent to auditors or litigators. This might not be helpful to the case of a clinician who is being audited. Perhaps clinicians should be able to make changes at the end of the day, but after a reasonably short amount of time has passed the record should lock. If information needs to be added or comments made after the entry has been locked,
a new entry should be written and clearly identified as an addendum, with current date, reference to the date being amended, the reason for the late entry, and electronic signature.

Risk reduction measure #13: Print out a note from time to time to be sure your entries are in your own name.

**Time Stamp Issues**

It is useful that EMRs record the time of a medical record entry. However, some clinicians became accustomed, in paper and pen days, to documenting procedures before they actually occurred. This is a problem when the record is electronic. For example, an obstetrician does not want a record to state that a child was born before a C-section was performed.

Risk reduction measure #14: Understand how the time stamp feature works.

**Confidentiality**

Under HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, facilities and practices need to make sure that only those individuals who have a legitimate reason to access a medical record may access the record. Legitimate
reasons include treatment, health care operations, and payment. If a patient finds out that someone who has no business being in the chart has had access, the patient may report the individuals involved and the U.S. Office of Civil Rights may prosecute.

Risk reduction measure #15: Ensure that only appropriate staff have access to records. Create a process to handle staff breaches of security. Have password protected log-in. Have automatic sign-out if a clinician forgets to log out.

Risk reduction measure #16: Protect records from inappropriate viewing—set up screensavers and require a password for reentry.

Risk reduction measure #17: Develop and implement security measures to protect the confidentiality of health information that is transmitted electronically.

Risk reduction measure #18: Identify an individual responsible for security.

It is likely to take another decade before the medical community fully appreciates all of the unintended consequences—legal and otherwise—of EMRs.
Meanwhile, it makes sense to purchase a system that has been used for a few years by other practices or facilities, learn the system’s safety features, and commit to interact with the features that are most likely to reduce the risk of medical errors.

Notes
1. The right to self-determination was explained by J. Cardozo in 1914: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a [physician who administers treatment] without his patient’s consent commits an assault for which he is liable in damages.” *Schloendorff v. Society of N.Y. Hospital*, 211 N.Y. 25, 105 N.E. 92 (1914).


3. For example, in *Head v. Colloton* [331 N.W.2d 870, 875 (Iowa 1983)], the court said, “Treatment is broad enough to embrace all steps in applying medical arts to a person.” In *Patrich v. Menorah Med. Ctr.* [636 S.W.2d 134 (1982)], the Missouri Court of Appeals defined treatment as “measures necessary for physical well-being of the patient.” Treatment is defined as including “examination and diagnosis as well as application of remedies” Black, H. (1990). *Black’s law dictionary* (6th ed., p. 1502). St. Paul, MN: West Publishing.

4. In this case, administration of oxygen in high doses caused blindness in the infant.

5. The court used the doctrine of informed consent, even though the issue was not one of consent but of knowledge of an abnormality requiring further evaluation.
6. A duty arises whenever a doctor becomes aware of an abnormality that may indicate risk or danger. The facts that must be disclosed are all those facts that the physician knows or should know that the patient needs to make a decision about treatment. Id. at 923.


Chapter 9: Reimbursement for Nurse Practitioner Services

Although a small minority of patients pay their own medical bills, most encounters between a nurse practitioner (NP) and a patient include a third-party participant—the payer. Whether an NP is employed by a medical practice or self-employed, the reimbursement policies of third-party payers often will determine whether an NP continues to provide care on a long-term basis.

Payers
There are five major categories of third-party payers:

1. Medicare
2. Medicaid
3. Indemnity insurance companies
4. Managed-care organizations (MCOs)
5. Businesses that contract for certain services
Each type of payer has its own reimbursement policies and fee schedules, and each operates under a separate body of law. Some payers reimburse NPs in the same manner that they reimburse physicians. On the other hand, some payers have NP-specific rules and policies regarding reimbursement. Not every payer will pay every NP for every service.

**Medicare**
Medicare is a federal program, administered nationally by the Centers for Medicare and Medicaid Services (CMS) and administered locally by Medicare administrative contractors. Medicare covers two groups: (1) individuals 65 years and older who have enrolled and pay premiums and (2) disabled individuals who qualify for Social Security disability payments and benefits.

Medicare pays for the care of an enrolled patient under one of two arrangements. If a patient covered by Medicare is not enrolled with an MCO, Medicare reimburses the patient’s healthcare provider on a fee-for-service basis through a local Medicare agency. If a patient has enrolled in a managed care health plan, there is an extra payment step between the payer and the provider. Medicare pays the health plan on a capitated basis, an all-inclusive
lump sum per month for each patient. Health plans then pay providers on a fee-for-service or capitated basis.

**Fee-for-Service Medicare**

Fee-for-service reimbursement is payment for specific healthcare services under a fee schedule. A health service might be an office visit, surgery, ear irrigation, suturing of a wound, a Pap smear, or any one of thousands of others. Fees are based on a complex variety of factors, including the number and type of services provided, the Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) codes, the geographic area of service, and certain office and training expenses of the provider. A provider or group may receive additional fees if the provider or group meets specified quality measures. All reimbursable services have a CPT code. CPT is a uniform coding system developed by the American Medical Association and adopted by third-party payers for use in claim submission. All CPT codes have a corresponding Medicare fee. All medical diagnoses have an ICD code.

Fees for CPT codes may vary in different locations and for different providers depending on a complex variety of factors, including the geographic area of
service and particular office, malpractice, and the training expenses of the provider. Under Medicare, NPs may be reimbursed at a rate of 85% of the Physician Fee Schedule. Under a fee-for-service system of reimbursement, the more services an NP performs, the more money he or she will generate.

The Physician Fee Schedule is determined using a system called a resource-based relative value scale (RBRVS). The RBRVS, developed by CMS, the federal agency charged with administering Medicare, determines reimbursement for Medicare Part B services. The RBRVS assigns a relative value to each procedural code (CPT code). Under the RBRVS system, services are reimbursed on the basis of resources related to the procedure rather than simply on the basis of historical trends.

There are three components to a relative value: (1) a practice expense component, (2) a work component, and (3) a malpractice component. Each component is adjusted geographically, using three separate Geographic Practice Cost Indexes (GPCIs). The final formula to arrive at an area-specific relative value is:

\[
(\text{Practice Expense RV} \times \text{Practice Expense GPCI}) + (\text{Work RV} \times \text{Work})
\]
GPCI) + (Malpractice RV × Malpractice GPCI) = Relative Value

The relative value is then multiplied by a single “conversion factor” to arrive at the geographic-specific fee schedule allowable for a given area. The conversion factor is based on whether the service is surgical or medical. RBRVS affects payments made to physicians, NPs, and other providers entitled to Medicare and other forms of third-party reimbursement.

An NP wishing to provide service to a Medicare patient on a fee-for-service basis applies to be a Medicare provider. Once the NP has a provider number, he or she submits bills to the local Medicare carrier agency for each visit or procedure. A standard form, the CMS 1500, is used. NPs who are self-employed receive 85% of the physician charge for the billed procedure. When an NP is employed by physicians and can meet “incident to” requirements, the practice may receive 100% of the physician charge for the billed procedure, subject to the “incident to” rules.

“Incident to” Services
The full term for “incident to” is “incident to a physician’s professional service.” The term is
particular to Medicare. The legal definition of “incident to” services is services furnished as an “integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness.” To qualify under this definition, the services of nonphysicians must be rendered in a physician’s office under a physician’s “direct personal supervision.” Nonphysicians must be employees of a physician or physician group or have an independent contractor relationship with the group. Services must be furnished during a course of treatment in which a physician performs an initial service and subsequent services of a frequency that reflects the physician’s active participation in and management of the course of treatment. Direct personal supervision in the office setting does not mean that a physician must be in the same room. However, a physician must be present in the office suite and immediately available to provide assistance and direction throughout the time that an NP is performing services. “Incident to” may refer to the services of office nurses and technicians as well as NPs.

**Capitated Medicare**

Capitation is a fee paid by an MCO to a healthcare provider, per patient, per month, for care of an MCO
member. Capitated fees for primary care vary, based on a patient’s age and sex. Under a capitated system of reimbursement, NPs and physicians are paid a set fee per patient per month for all services agreed to by contract. If an NP has agreed to provide all primary care services for a patient, then the NP must provide an unlimited number of primary care visits. On the other hand, if a patient never visits, the NP operating under a capitated system of reimbursement still is paid.

An NP wishing to provide care for a Medicare patient enrolled in an MCO applies to the MCO for admission to the organization’s provider panel. For information about applying for admission to managed-care provider panels, see Exhibit 9-1.

Exhibit 9-1 How to Apply for Provider Status
First, apply for a National Provider Identifier online, through the National Plan & Provider Enumeration System (NPPES).

Medicare

1. Apply for provider status through the CMS website.
2. Bill Medicare electronically on a form called CMS 1500, using the patient’s
name and identifying information, the
diagnosis code (ICD), the procedure
code (CPT), the charge, and the NP’s
provider number.

3. If a Medicare patient is enrolled in
managed care, see the “Managed-
Care Organizations” section of this
exhibit.

**Medicaid**

1. Apply through the state Medicaid
agency. Ask for Provider Relations,
and then ask for a provider application
as an NP.

2. Bill the state Medicaid agency on a
CMS 1500 form, using the patient’s
name and identifying information, the
ICD code, the CPT code, the charge,
and the NP’s name, provider number,
and location.

3. If a Medicaid patient is enrolled in
managed care, see the “Managed-
Care Organizations” section of this
exhibit.

**Indemnity Insurer**
1. Call the company to inquire whether a provider credentialing number is required. If so, apply. If not, submit a CMS 1500 form to the company for the services rendered.

2. If the company rejects a bill, the company will return the CMS 1500 with a short explanation about why it is being rejected. If the rejection is erroneous, write a letter to the company protesting the rejection and explaining the error, if possible, or supply whatever further information is needed. Sometimes several letters will be necessary before a bill is paid. Sometimes it will be necessary to include a copy of the appropriate law with the correspondence. Occasionally, intervention by a practice’s attorney is necessary. Occasionally, a company will persist in refusing to pay. If so, the patient is liable for the bill.

Managed-Care Organizations

1. Call Provider Relations for each MCO for which admission is needed, and request an application for admission to
the panel of providers. Many MCOs want providers credentialed through the Council for Affordable Quality Healthcare. Apply online through that organization’s website.

2. If rejected, note the reason for rejection and, if applicable, consult state insurance law. In some states, an HMO or MCO cannot discriminate among providers on the basis of class of license. In other states, HMOs can accept or reject any provider. Ask for an opportunity to present the case for admitting NPs to the provider panel. Pursue a company through letters, presentations, meetings, and telephone calls, going up the supervisory line if necessary.

Individuals covered by Medicare may choose between traditional fee-for-service coverage and managed care.

**Medicaid**

Medicaid is a federal program, administered by the states, for mothers and children who qualify on the basis of poverty and for adults who are disabled for
the short term—1 year or less—and who qualify on the basis of poverty.

Like patients covered by Medicare, some patients covered by Medicaid are enrolled in MCOs and others are not. To serve a Medicaid patient not enrolled in an MCO, an NP must apply and be accepted as a Medicaid provider by the state Medicaid agency. To serve a Medicaid patient enrolled in an MCO, an NP must apply and be admitted to the provider panel of the MCO in which the patient is enrolled.

Medicaid pays NPs 70–100% of the fee-for-service rates set for physicians by state Medicaid agencies. State law controls the rate. Medicaid reimbursement generally is lower than the rates paid by commercial insurers. For information on rates, contact the state Medicaid agency.

Many states have applied to the federal government for “Medicaid waivers.” A Medicaid waiver gives permission to a state from CMS to administer Medicaid in ways that differ from the federal laws and regulations, specifically, to enroll patients covered by Medicaid in MCOs. Once a state has received a Medicaid waiver, NPs can expect that most, if not all, patients covered by Medicaid will
enroll in MCOs or other managed-care plans. NPs who have served Medicaid patients on a fee-for-service basis must apply for admission to the appropriate managed-care provider panels to maintain reimbursement.

**Indemnity Insurers**

An indemnity insurer is an insurance company that pays for the medical care of its insured but does not deliver health care. Indemnity insurers pay healthcare providers on a per-visit, per-procedure basis. To obtain reimbursement, an NP submits a billing form to the insurance company (see “Billing Third-Party Payers” and “Billing Self-Paying Patients” later in this chapter).

Until a few years ago, indemnity insurers had fee schedules based on “usual and customary” charges. “Usual and customary” is an insurance industry term for a charge that is (1) usual and customary when compared with the charges made for similar services and supplies and (2) made to persons having similar medical conditions in the county of the policyholder or such larger area than a county as is needed to secure a representative cross section of fees. “Usual and customary” could be calculated differently from insurer to insurer.
Therefore, some insurers pay more than others for the same procedure.

In the past, if a provider charged more than what an insurer considered to be “usual and customary,” the insurer paid only the usual and customary charge. In that case, the patient was responsible for the difference between what a provider charged and what an insurer paid. It was up to the provider to collect the difference from the patient. Some providers agreed to accept the “usual and customary” payment and did not pursue patients for the difference. Other providers pursued patients for the provider’s full charge, no matter what portion was paid by an insurer.

Today, fee schedules are negotiated between provider and payer. The fee schedule may or may not be based on what is usual and customary. If a payer understands that many providers will accept a fee for a service, then the provider who wants a higher fee will be in a poor negotiating position. On the other hand, where providers are scarce, they are in a better position to negotiate higher fees.

Individuals who do not have health insurance and who therefore pay their own medical bills often are in the unfortunate position of paying a much higher
price than insurers and health plans, who have negotiated discounts from practice and facility fee schedules.

**Managed-Care Organizations**

An MCO is an insurer that provides both healthcare services and payment for the services. MCO is an umbrella term that may include HMOs and other forms of health plans. An HMO is a prepaid, comprehensive system of health benefits that combines the financing and delivery of health services to subscribers.

NPs are increasingly gaining admission to MCO provider panels. With panel membership comes the designation primary care provider (PCP), a contract for providing care, credentialing, directory listing, and reimbursement.

A PCP has full responsibility for a patient’s primary care, including (1) complying with the MCO’s quality, utilization, and patient satisfaction standards; (2) coordinating care with specialists, hospitals, or long-term care facilities; (3) approving or denying referrals for specialty care; (4) keeping costs as low as possible while maintaining quality; and (5) providing a system for 24-hour access to care. “Medical home” is a term associated with
many of the same responsibilities as a PCP, with emphasis on attending to the patient’s preventive care, coordination of care, and achieving positive outcomes. When a provider is a patient’s medical home, the provider may be eligible for enhanced reimbursement. NPs are eligible to provide medical homes under some state programs.

MCOs reimburse PCPs on a fee-for-service basis, a capitated basis, or a combination of fee-for-service and capitation. Each MCO negotiates a payment arrangement with each group, practice, or provider on its panel. (See “Negotiating an MCO Contract” later in this chapter.)

How MCOs Work
MCOs sell a priced package of health services to their clients, who may be employers, individuals, or government agencies, such as the state Medicaid agency or Medicare. A client signs up for a particular plan and offers that plan to patients, or “members,” who often share in the cost of the plan. Each MCO has a panel of healthcare providers who may or may not be employed by the MCO.

Group-Model Versus Practice-Model MCOs
There are two types of affiliation between MCO and provider. The first type is an employer–employee arrangement, called the *group-model MCO*. The best known group-model MCO is Kaiser Permanente. A group-model MCO pays a provider a set salary in return for taking care of a panel of patients. In the second type of affiliation, called the *practice-model MCO*, the MCO contracts with independent providers, group practices, or practice associations for a “product line” of services. Contracts between an MCO and a practice govern the relationship. (See “Negotiating an MCO Contract” later in this chapter.)

Some group-model and practice-model MCOs are allowing patients to choose NPs as PCPs. Not all MCOs currently recognize NPs as PCPs, however.

**Applying for MCO Provider Panel Membership**

If an NP is employed by an institution or a group, the employer usually takes care of setting the NP as a provider with the MCOs, though the NP may need to fill out the paperwork. If the NP is operating his or her own practice, then the NP will need to do the ground work described below.
NPs should determine which MCOs are prevalent in their geographic area of practice and prevalent among their practice’s patients. Once an NP has compiled a short list of MCOs, it is wise to do some research on them.

The NP can ask other providers who have done business with the MCO, or the state agency that oversees MCOs, the following questions:

- Have other providers been paid promptly?
- Who are the specialists in the MCO’s referral network? Are you familiar with them?
- Does the MCO have a strong presence in the community?
- Is the MCO financially sound?
- Is the MCO’s record with the Insurance Division relatively free of complaints?
- Does the company have decent-quality data?

The NP should apply to the MCOs for which all these answers are yes.

NPs who have been admitted to MCO provider panels are (1) those whose practice is in a geographic area of interest to an MCO, (2) those who have large numbers of patients who are attractive to the MCO, (3) those who offer a service unavailable elsewhere, or (4) those who have been
endorsed and supported by the physicians in a large group practice. In general, these are the same characteristics that distinguish the physicians who have been admitted to MCO provider panels.

In brief, the application process entails (1) calling Provider Relations at an MCO and requesting an application, (2) applying for admission, and (3) following up by telephone or letter.

**Provider Credentialing**

When MCOs deem providers “credentialed,” it means that they have collected educational, license, malpractice, employment, and certification data on the providers and made a judgment that the providers are adequately prepared to care for the MCOs’ patients. For the information commonly required of applicants to provider panels, see **Appendix 9-A**.

An MCO interested in an NP as a panel member will verify data submitted on the application and may make a site visit. A site visitor looks for a clean office, safe access, sufficient parking, adequate staffing, and other signs of a well-organized practice. In the case of an NP practice, a site visitor may ask about systems for admitting patients and access to a physician consultant. An offer of
admission to a provider panel will come with a contract, to be signed by the NP and the MCO.

**Negotiating an MCO Contract**

Contractual relationships with MCOs cover not only compensation but also many other practice areas. Some attorneys specialize in assisting providers to negotiate contracts with MCOs, and NPs are encouraged to seek counsel of an attorney experienced in these matters. A detailed explanation of the contract issues described here is beyond the scope of this text. There are books devoted entirely to negotiating managed-care contracts.

Contract issues to be negotiated include the following:

- What is included? What is excluded?
- What are the carve outs, that is, what patients are treated in special programs because of special needs?
- What is the process for transferring the care of a patient who becomes eligible for a carve out?
- What is the fee schedule or capitation schedule?
- What are the stop-loss provisions?
- Are there withholds?
- Are there referral pools?
- What is the level of distributions from withhold and referral pools to PCPs during the last 5 years?
- What is the bonus system?
- What are the provisions for closing the practice to additional patients from the MCO?
- Is claims processing done in-house or contracted out?
- Who does the lab work?
- On what will the MCO base renewal? What is its renewal rate with providers?
- What is the procedure for the MCO’s review of office practices?
- How will the directory listing read?
- Is there any prohibition against joining other MCOs?
- How does the MCO define experimental, emergency, and preexisting conditions?
- Who bears the brunt of the consequences for a mistake regarding eligibility or coverage determination?
- Can preadmission or referral approval be rescinded retroactively?
- What is in the formulary?
- What are the requirements for:
  - Utilization management
  - Quality assurance
  - Credentialing
- Member grievance
- Record keeping
- Claims submission
- Hours of operation
- Appointment response times
- On-call coverage
- Employing other providers
- Arranging backup with other groups
- Minimum/maximum numbers of patients
- Anti-disparagement
- Business confidentiality

- What is the system for verifying member eligibility? How often is the provider notified of members who have selected him or her? When in the month is this done?
- What are the provisions for dispute resolution?
- What are the provisions for member grievance?
- What marketing is provided by the MCO?
- Who owns the records/data?

If an NP is an employee of a group practice, then someone within the group will be responsible for negotiating the terms of the MCO contract for the group. An NP who owns a practice will need to negotiate the points just discussed individually or join a practice association in which there is a designated negotiator.
Some providers join provider groups for the express purpose of collectively negotiating contract terms and rates. While some providers enter into a contract with an MCO without experienced legal counsel, it is unwise to do so.

**Steps for Dealing with Denial of Provider Status**

**Gather Information**
An NP who is denied a request for an application should ask the following questions of an MCO representative:

- Does the MCO admit NPs to provider panels?
- If not, why not?
- If it is a policy matter, who is the decision maker in the company who could change the policy?
- If state law is given as a reason for denial, ask which law precludes NPs being PCPs.

**Strategize**
Given that there may be more providers wanting provider status than an MCO wants to credential, the NP needs to analyze his or her strengths and be prepared to convince the MCO that it should credential him or her. The NP should ask for a meeting with an individual at the MCO who is in a position to make a decision and present the reasons why the MCO should take him or her on as a
provider. If there are other NPs in the area who are facing the same problem, NPs can enlist the help of their state NP organization. It may also be helpful to hire an attorney to analyze an alleged legal barrier and to determine whether, in fact, it is a true legal barrier. Note, however, that MCOs often have wide latitude to admit the providers of their choice. Persuasion is more likely to be effective than litigation. Sometimes an MCO will be precluded by state law from taking on NPs as PCPs. If there are legal barriers to NPs becoming panel members or PCPs, NPs can hire a lobbyist who will work to change the law.

NPs should research options for using existing state law to encourage MCOs to admit NPs to provider panels. For example, some state laws preclude discrimination by MCOs against classes of healthcare providers who are legally authorized to provide healthcare services. NPs or their attorneys will want to cite such laws when making presentations to MCO executives.

**Take Action**

If an MCO has a policy against admitting NPs as PCPs, NPs may employ the following actions to effect a policy change:
Write letters to MCO presidents, stating how NPs can satisfy the business needs of the MCO. Ask for an informational meeting, and present information on NP scope of practice, sources of third-party reimbursement, and arguments supporting NPs as PCPs, backed up by supporting data.

Ask patients to request, through their employer’s benefits office and through their MCO, the services of an NP as PCP.

Ask colleague physicians to support NP admission to provider panels.

Testify at hearings and speak at community meetings about the advantages of having NPs as providers.

Ask for language changes from businesses that use the following message: “Ask your doctor.” Ask that the language be changed to “Ask your doctor or NP” or “Ask your healthcare provider.”

In 6 months, request an application and try again.

**Carrying Out an MCO Contract**

NPs who are admitted to MCO provider panels will want regular periodic analysis of the income and expense associated with each MCO contract. Such an analysis might reveal that a practice is losing money on one contract while breaking even on another and making a profit on yet another. If there
is a discrepancy in reimbursement from various MCO contracts, an NP will want to determine the reason for the unprofitability of certain contracts and either negotiate a different arrangement when the contract expires or cease to deal with an MCO.

NPs also will want to evaluate MCO contracts regarding the effect of the contract on staff and providers. For example, is one MCO’s paperwork or procedures for reimbursement overwhelmingly more complicated than another’s? If so, then whatever reimbursement is being reaped may be offset by costly staff services. Is the lag time between services and payment greater than 120 days? If so, the practice manager will need to insist on prompt payment or cease to deal with the offending MCO.

**Direct Contracts for Health Services**

There are no barriers to the NP who wishes to contract directly with businesses or agencies that need health services. For example, NPs contract directly with some colleges to provide college health services, with businesses to provide occupational health services, and with government agencies to provide school-based health services.

**Billing Third-Party Payers**
Billing third-party payers includes filing the proper forms, including the appropriate diagnostic and procedure codes, and documenting encounters in the medical record in a manner that justifies a bill. It also involves following up denied claims and claims that have not been paid in 30 days.

**Standard Form**
The standard billing form is the CMS 1500. It can be accessed through an electronic billing system or purchased from the American Medical Association and from other commercial suppliers such as bookstores. The CMS 1500 form asks for ICD codes, CPT codes, date of service, patient identifying information, and provider identifying information. A bill submitted without a CPT or ICD code will be rejected.

Currently the vast majority of billing is done electronically, so most practices are contracting with billing services or purchasing software rather than buying forms.

**Coding**
The most frequently used CPT codes in primary care are the Evaluation and Management (E&M) Services. Specialty practices use the E&M codes as well. E&M codes represent a healthcare provider’s
cognitive services, such as office or clinic visits, consultations, preventive medicine examinations, and critical care services. In addition to E&M codes, a primary care practice will use other CPT codes to bill for such procedures as suturing and irrigation of ears.

E&M codes require providers to bill on the basis of the extent and complexity of history taking, physical exam, and medical decision making. For an example of E&M code requirements for a routine visit, see Exhibit 9-2.

### Exhibit 9-2 Selecting an E&M Code
A 99213 visit, the most common E&M code for an established patient, includes the following:

- An expanded problem-focused history
- An expanded problem-focused examination
- Medical decision making of low complexity
- Counseling and coordination of care consistent with the nature of the problem and the patient’s needs
- 15 minutes of face-to-face time
The following are examples of office visits:

- A 55-year-old male established patient for management of hypertension and mild fatigue, on hydrochlorothiazide and a beta blocker
- A 50-year-old female established patient with insulin-dependent diabetes mellitus and stable coronary artery disease, for monitoring

A typical bill for an office visit could list one or more CPT codes and one or more ICD codes. For example, a bill for a routine annual gynecologic exam would include ICD code V72.3 for a diagnosis of routine annual exam and CPT codes 99213 or 99214 for an office visit for an established patient, 87210 for a wet mount, and 87205 for a Pap smear.

CMS has published *Documentation Guidelines for Evaluation and Management*, which NPs and other Medicare providers will be expected to follow in
coding patient visits. (These guidelines are provided elsewhere in the text.) NPs should know that other insurers will expect the same attention to coding and documentation as CMS.

General guidelines for legal coding are as follows:

1. A billable visit involves face-to-face contact between the patient and an advanced practice nurse, physician assistant, or physician. An encounter may occur in the provider’s office, a clinic, an inpatient setting, a nursing facility, or the patient’s home. Each billable visit must be a diagnostic visit, identified with an ICD code.

2. If care is given in an office, an NP must distinguish between a new patient and an established patient and then select the proper E&M CPT code for the visit. A new patient is one who has not received professional services within the past 3 years from a provider in the same specialty in the same practice. Telephone communication is considered a professional service.

3. History taking, examination, and medical decision making are the key components in determining code selection. Time is the least important factor, unless the visit is a
“counseling” visit, there is significant time spent on coordination of care, or the visit qualifies as a “prolonged service.” In ambulatory care, only face-to-face time is to be considered in selecting an appropriate CPT code. The nature of the presenting problem also figures into the choice of CPT code, under medical decision making.

4. Medical record documentation must support the level of care billed. Underdocumentation can lead to charges of fraudulent billing or “false claims.” For every evaluation and management service billed, the medical record documentation must indicate the medical necessity for the visit.

5. A practice’s billing will include a variety of E&M codes because patient encounters vary in the amount of attention required. A provider with a pattern of coding all visits with one of the higher level codes, without documentation to justify the high-level visits, is likely to be identified by the Medicare carrier as an “upcoder,” that is, a provider who bills for a higher level of service than actually provided in order to get a higher fee. Upcoding is false claims. A normal distribution of E&M codes for established patients (99211 through
99215) is a bell-shaped curve, with most visits being 99213.

6. It is important to bill the CPT code that the medical record documentation supports, not a higher level code or a lower level code. Failing to bill for all billable services rendered can mean unnecessarily low revenues for a practice. Consistent overcoding without medical record documentation that supports the level of visit billed can result in an audit by the Medicare carrier, fines, criminal prosecution for Medicare fraud, loss of Medicare provider status, and loss of license.

Table 9-1 shows a comparison for the five levels of visit (99211 through 99215) for an established patient. For a complete discussion of choice of code, see Current Procedural Terminology for the current year, published by the American Medical Association. The CMS guidelines will be revised from time to time. A current copy of the guidelines can be found on the CMS website (http://www.cms.gov).

In general, the appropriate documentation for the codes for an established patient, mid-level visit (99213) is as follows. Under the documentation guidelines released on the CMS’s website in
November 1997 and still in effect in 2016, a bill for a 99213 visit will have to be backed up by a medical record entry that includes certain elements of history taking, physical examination, and medical decision making.

**Table 9-1** A Comparison of Requirements for the Five Levels of Visit for an Established Patient

<table>
<thead>
<tr>
<th>Level of Visit</th>
<th>History</th>
<th>Exam</th>
<th>*Diagnoses</th>
<th>*Data Reviewed</th>
<th>*Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>None required</td>
<td>None required</td>
<td>None required</td>
<td>None required</td>
<td>None</td>
</tr>
<tr>
<td>99212</td>
<td>1 descriptor</td>
<td>1</td>
<td>1 minor or established</td>
<td>Order or study 1 lab</td>
<td>1 minor problem, noninvasive labs, home-based management</td>
</tr>
<tr>
<td>99213</td>
<td>1 descriptor ROS</td>
<td>6</td>
<td>2 minor or established, or 1 new</td>
<td>Order or study 2 labs, summarize old records, or personally view tracing</td>
<td>2 minor problems, 1 chronic stable problem, or 1 acute problem; management is minor</td>
</tr>
<tr>
<td>99214</td>
<td>4 descriptors</td>
<td>12</td>
<td>1 new or 1 worse and 1 minor</td>
<td>Order or study 3 labs, order 1 lab and summarize old records, or personally view tracing</td>
<td>1 chronic problem, worse; 1 chronic problem, stable; or 1 acute systemic problem; invasive diagnostic procedures needed; prescription drugs indicated</td>
</tr>
<tr>
<td>99215</td>
<td>4 descriptors</td>
<td>18</td>
<td>1 new problem needing workup, or 1 new, stable and 1 minor</td>
<td>Order or study 4 labs, order or study 2 labs and summarize old records, or personally view</td>
<td>1 severe chronic problem, 1 life-threatening chronic problem, 1 acute life-threatening problem, or</td>
</tr>
</tbody>
</table>
tracing

acute mental status change; contrast studies or endoscopy with risk factors as indicated; parenteral therapies, fracture treatment, major surgery, or monitoring is indicated

*Two of these three components are needed.

Abbreviations: PFSH = past, family, and social history; ROS = review of systems

CPT five-digit codes, nomenclature, and other data are from © 2016 American Medical Association. All Rights Reserved. No fee schedules, basic unit, relative values, or related listing are included in CPT. The AMA assumes no liability for the data contained herein. CPT only © 2016 American Medical Association.

For example, CPT 2016 requires a clinician to document, in detail, two of the three key aspects of a visit. Key aspects of an office visit, according to CMS, are history, examination, and medical decision making. The guidelines also address documentation of three other elements of a medical
The November 1997 guidelines’ requirements to satisfy documentation requirements for history taking, examination, and medical decision making for a 99213 visit are given next, along with the guidelines’ discussion of documenting time, counseling, and coordination of services. The November 1997 guidelines are the most current guidelines, as of June 2016.

**History Taking**

Clinicians must document the following:

- At least one of the symptom descriptors (location, quality, severity, duration, timing, context, modifying factors, and associated symptoms)
- A review of systems for at least one pertinent body area or system; the acceptable body areas and systems are constitutional, eyes-ears-nose-throat/mouth, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, skin/breasts, neurologic, psychiatric, endocrine, hematologic, or immunologic

No past, family, or social history is required.

**Examination**
Clinicians must document at least six elements from a body system or area. Acceptable systems or body areas include constitutional, eyes-ears-nose-throat, neck, respiratory, cardiovascular, breasts, abdomen, genital, lymphatic, musculoskeletal, skin, neurologic, or psychiatric.

**Medical Decision Making**
According to the guidelines, medical decision making has three components: (1) making a diagnosis, (2) choosing treatment options, and (3) reviewing data. Clinicians are to consider one additional factor when choosing a code and documenting the risk of complications and/or morbidity or mortality. For a 99213 visit, medical decision making is “low complexity” under the guidelines.

According to the guidelines, the diagnostic component of medical decision making is fulfilled by documenting a “limited” number of diagnoses or management options. Auditors verifying a 99213 visit will be looking for diagnoses for at least two minor problems, or two established stable problems, or one established problem that is documented as worse and one minor problem, or one new problem that is stable or in need of workup.
As for the component of medical decision making that consists of reviewing data, the guidelines give examples of what indicates increased complexity in a visit—a personal review of an electrocardiogram tracing, for example—but the guidelines do not list what documentation is needed to justify a particular level of visit. Auditors’ score sheets require, for a 99213 visit, that a clinician document that diagnostic tests have been ordered or reviewed; that an X-ray, tracing, or slide interpreted by another clinician has been reviewed; or that old history has been summarized.

The guidelines appear on the CMS website (http://www.cms.gov; use the search engine to find “Evaluation and Management Guidelines”). The auditors’ score sheets are available to clinicians on the websites of Medicare Administrative Contractors.

As for the final component of medical decision making, the risk of complications and/or morbidity or mortality, the guidelines are more specific. For a 99213 visit, the risk is “low.” Examples of low risk for complications are visits where there are two or more self-limited or minor problems, a stable chronic illness, or an acute uncomplicated illness or injury. Diagnostic procedures that might be ordered during
such a visit are physiologic tests not under stress, such as pulmonary function tests, clinical laboratory tests requiring arterial puncture, or skin biopsies. According to the guidelines, management options could include over-the-counter drugs, minor surgery, or physical therapy.

**Time**
Time is a minor consideration in determining the level of visit to bill, according to the guidelines, if aclinician is billing an office visit for evaluation and management (99211–99215 for an established patient and 99201–99205 for a new patient). If a visit is primarily counseling, however, time matters and should be documented. The visit is billed as a counseling visit, not as an evaluation and management visit.

**Counseling and Coordination of Services**
While clinicians are expected to document patient counseling and coordination of services, there are no specific guidelines for this documentation. The guidelines state that it is expected that documentation will reflect the appropriate level of counseling and coordination based on patient needs.

**Rejected Bills**
If a bill is rejected by a payer, a member of the medical practice’s staff should ask the following questions of the payer, document responses, and follow up by letter:

1. Why was this bill rejected?
2. Is more information needed about the procedure? About the diagnosis? About the documentation? About the NP’s practice?

Every practice should have copies of relevant law regarding NP reimbursement. Relevant law includes the state regulation or statute that gives NPs the authority to provide care, the section of the Medicaid and Medicare regulations that apply to NP reimbursement, and any parts of the state insurance law that mandate payment for services provided by NPs. If bills are rejected for reasons related to NPs as a profession, the practice should send copies of relevant laws to insurers, along with any other information the payer requests.

**Billing Self-Paying Patients**  
Though patients who pay their bills themselves are not, by definition, third-party payers, they deserve mention as a source of reimbursement.
Cash at time of service works only when patients are aware of what the bill will be before they arrive for their visit. Many practices are unable to give patients that information, but some can.

Some practitioners take credit cards. Some allow patients to run a balance with the practice and pay a monthly installment. Many practitioners who extend credit to patients have found it necessary to establish a relationship with a collection agency.

**Conclusion**
Reimbursement is a high-stakes issue for any practice, for without steady income, no practice will survive. Each of the topics discussed in this chapter deserves a book’s worth of discussion. In fact, there are publications available on every topic. For sources of more information, see the section titled “Resources.”

**Note**
1. Medicare Benefit Policy Manual, Chapter 15, Sections 60.1–60.3.

**Resources**

**Billing Nurse Practitioner Services**
the author’s website at
http://www.buppert.com/publications

http://www.buppert.com/publications

http://www.buppert.com/publications

http://www.buppert.com/publications

Managed-Care Quality Standards
National Committee on Quality Assurance.
**Diagnostic Coding**  
*International classification of diseases.*  
Chicago, IL: Author.  

Note: Always use the most current edition.  

**Procedural Coding**  

Note: Always use the most current edition.
Appendix 9-A: Credentialing Information

A typical credentialing application will ask for the following:

- The NP’s name, and other names used in past licensure and certification
- States of licensure
- Type of license
- Specialty
- Subspecialty
- National Provider Identifier (NPI) number
- Social Security number
- Birth date
- Proof of U.S. citizenship
- Place of birth
- Home address and telephone
- Practice status (individual, partnership, or group)
- Practice name, address, telephone, tax identification number, and office manager
- Dates of service at this practice
- Undergraduate and graduate education: institution, address, dates attended, degrees conferred
- Postgraduate training: institution, address, dates attended, type of training, name of program director, specialty
- Fellowship training: institution, address, dates attended, type of training, name of program director, leadership positions held, reason for leaving, type of facility
- Employment history/professional affiliations: institution, address, dates of privileges, position title, leadership positions held, name of department chair, type of facility, reason for leaving
- Current admitting privileges: primary admitting hospital, address, date received privileges, staff category, leadership positions held, name of department chair
- Military service: branch, period of enlistment, discharge status, rank
- Specialty board certification:
  - Board, year certified or recertified, expiration date
  - If you are not certified, whether you have taken the certification examination
  - Number of times you have taken the examination
  - Date that your eligibility to take the examination expires
- Whether you intend to apply for the certification examination
- Whether you have been accepted to take the certification examination
- Date of next certification examination

- Licensure:
  - States, license number, expiration date, current status
  - Drug Enforcement Administration (DEA) license number, expiration date, current status
  - State controlled-substance license number, expiration date, current status

- Professional liability coverage:
  - Proof of current coverage, name of previous carrier, period of coverage, limits of coverage, type of coverage, reason for discontinuance
  - Whether you have maintained continuous professional liability coverage since first obtaining coverage
  - Whether you have been subject to a professional liability suit, including but not limited to malpractice claims, in the past 5 years
  - Whether there are any restrictions, limitations, or exclusions in your current
professional liability coverage
- Whether your professional liability insurance coverage has ever been denied, limited, reduced, interrupted, terminated, or not renewed

- Personal information:
  - Date of last physical examination
  - Whether you are currently suffering from, or receiving treatment for, any physical or mental disability or illness, including drug or alcohol abuse, that would impair the proper performance of your essential functions and responsibilities as a healthcare provider
  - Whether you have ever been convicted of, or pleaded guilty to or nolo contendere to, any crime other than traffic violations

- Professional sanctions:
  - Whether your license to practice any health occupation in any jurisdiction has ever been limited; suspended; denied; subjected to any conditions, terms of probation, or formal reprimand; or not renewed or revoked
  - Whether you have surrendered your license to practice any health occupation in any jurisdiction
  - Whether your request for any specific clinical privilege has ever been denied or granted
with stated limitations

■ Whether you have ever been denied membership on a hospital medical staff
■ Whether your staff privileges, appointment, and/or delineation of privileges at any hospital or other healthcare institution have ever been suspended, revoked, limited, reduced, denied, subject to any conditions, or not renewed
■ Whether your DEA or other controlled-substance authorization has ever been limited, suspended, denied, reduced, subject to any conditions or terms of probation, or not renewed or revoked
■ Whether proceedings toward any of these ends have ever been initiated
■ Whether your controlled-substance authorization has ever been voluntarily or involuntarily relinquished
■ Whether you have ever been subject to disciplinary action in any medical organization or professional society
■ Whether there are any disciplinary actions pending against you
■ Whether you have resigned from any hospital or healthcare institution or professional academic appointment
• Whether you have ever been placed on probation, suspended, asked to resign, or terminated while in a training program
• Whether you have ever been placed on probation, suspended, asked to resign, or terminated while in a hospital program
• Whether you have ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned before a decision was made by a hospital’s or healthcare facility’s governing board
• Whether you have ever been denied certification or recertification by a specialty board or received a letter of admonition from such a board or committee
• Whether you have ever been investigated by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program
• Whether you have ever been subject to probation proceedings or suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program
• Whether you have received a determination from any professional review organization indicating a “final severity level 3” or a “gross and flagrant” quality concern
- Professional references: List names and addresses of four persons who have worked extensively with you or have been responsible for professionally observing you. Do not list more than two current partners or associates in practice, relatives by blood or marriage, the chief of service to whom you are applying, any person in current or past training programs with you (unless he or she is now a colleague), or persons who cannot attest to your current level of clinical competency, technical skill, and medical knowledge.
Chapter 10: The Employed Nurse Practitioner

The majority of nurse practitioners (NPs) are employed by others, rather than self-employed. The advantages of employment by others are:

- A built-in collaborative agreement, in states where these are required
- No struggles for reimbursement from third-party payers, who may balk at paying NPs directly but are comfortable reimbursing physician practices that employ NPs
- No responsibility, or limited responsibility, for day-to-day operations, payroll, marketing, and personnel matters

The disadvantages of employment by others are:

- The NP may be told how to practice, and the NP may disagree with the employer’s decisions.
- The NP can be fired or laid off.
- While the NP likely will get a salary, the NP may or may not share profits. Any decision regarding
profit sharing is up to the employer.

**What Rights Does an Employed NP Have?**

**At Will Employment**

In most states, employment is “at will.” This means that employment continues at the will of both parties. Put another way, either party may terminate for any reason at any time. Unless an employee has a contract for a specified term of employment, an employee has no legal right to a job. Likewise, an employee may also end employment at any time, barring a contract for a specified term. The only protections for an employee are those offered by the equal opportunity and disability laws; that is, an employee cannot be terminated solely on the basis of age, national origin, gender, race, religion, or disability.

NPs who are employed but have no contract must negotiate terms of employment on a piecemeal basis, relying on their ability to reach an agreement with the employing parties as issues arise. If an employer changes the pay scale or work responsibilities for the better, the NP benefits. However, if the employer reduces the pay scale or unreasonably increases responsibilities, the NP has no recourse but to keep working under the new conditions or to leave.
Employment by Contract

Many NPs seeking employment are offered employment contracts. An employment contract is a written agreement under which the employee and employer agree on the terms and conditions of their working relationship.

Employment contracts can be complex and lengthy, and they require careful analysis. The following is a list of some of the issues often addressed in an employment contract:

- Scope of services to be performed
- Compensation
- Duration of employment
- How the agreement can be altered or updated
- Responsibility for maintaining credentials
- Terms of on-call responsibilities
- Benefits
- Time off and expenses for continuing education
- Vacation time
- Number of office hours per week
- Restriction on competition
- Bonuses
- Reasons for termination
- Assistance with continuing education

Some issues that often are not addressed but can be dealt with in an employment contract include the
following:

- Extent of support service to be offered to the NP
- Expectations regarding the number of patients seen per day
- Expectations regarding nonclinical (administrative) work to be done by the NP
- Listing of the NP on the door, in directories, and in advertisements
- Use of the NP’s name when the office telephone is answered
- On-call responsibilities and backup
- Release to the NP of the NP’s quality performance as measured by health plan auditors

An employment agreement can include anything the parties wish to address. Often, agreements are written by attorneys for the practice and therefore are oriented to the needs of the employer. NPs should retain their own attorneys to review any proposed contract and respond with counterproposals when the contract language does not mesh with their needs.

**Does an NP Need a Contract?**

Many NPs practiced for many years without employment contracts. In the past, an employer called to offer a job, and the employer and
employee then negotiated a salary, benefits, and the hours of employment. The arrangement was typically sealed with a handshake. Details were worked out as issues arose, but NPs sometimes were unhappy with how they were handled.

Contracts have certain advantages over this informal employment arrangement. First, contract negotiation forces parties to discuss issues. When the parties agree to terms, there is a document that records the agreement and can be referred to as necessary to refresh memories about the details of the agreement. In most cases, an employment agreement is protective to both the employer and the employee.

For an employee, a contract may ensure some degree of job security. In most states, unless there is a written contract defining the duration of employment, employment is at will. As discussed, this means that either party may terminate the employment without cause at any time. For example, a practice that hires an NP and then loses a lucrative patient care contract can terminate an NP who is employed at will with no severance pay, even though the NP is not at fault. At will employees are often surprised to learn that they have no legal right to their jobs. An NP who has a contract,
however, may have an agreement for work for the duration of the contract, unless a clause in the contract states otherwise. An employer who wants to end the employment of the NP must wait until the contract terminates or attempt to settle the matter with the NP, possibly by offering severance terms. Note, however, that some employers’ contracts specify a term of employment (usually 1 year) but also say the employment is at will. That means an NP is bound to the terms of the contract for 1 year, but if the employer wants to end the arrangement sooner than that, the employer can terminate the NP at any time. If an NP sees such language in a contract, the NP who wants a guaranteed position for at least 1 year should negotiate that the at will term be deleted.

For an employer, an employment agreement can afford protection against competition. An employer wants to avoid a situation where a departing NP who has built a patient following takes patients to his or her next position. An employer can restrict a departing NP from competing with a practice by including a restrictive covenant (discussed shortly) in the employment agreement.

A multitude of issues that affect lifestyle and work style can arise among coworker healthcare
providers. An employment contract can delineate the expectations of employer and employee before problems arise. A contract also can specify problem-solving procedures.

**Three Difficult Clauses**

Three clauses commonly found in employment agreements offered by medical practices to NPs are especially difficult for NPs to interpret and can have profound effects on an NP’s life. These clauses address restrictive covenants, bonus formulas, and termination clauses. These clauses often bring NPs to attorneys for advice. *Restrictive covenants* require an NP to promise, up front, not to compete with an employer when the present employment ends. *Bonus formulas* specify conditions under which an employer rewards an NP for superior performance. *Termination clauses* specify that an employer may end the agreement, without cause, with 30 days’ notice.

**Restrictive Covenants**

A restrictive covenant is a promise not to compete. Specifically, a restrictive covenant is a clause that restricts an employee from practicing within a set number of miles from an employer’s business for a set period of time after the employee leaves the employer’s business.
Many employers insist on restrictive covenants. An employer wants to avoid a situation where a departing NP who has built a patient following takes patients to his or her position, often a neighboring practice.

Restrictive covenants are legal in many states and enforceable as long as they are reasonable. If a former employee challenges the validity of a restrictive covenant by taking the matter to court, a judge will determine whether it is reasonable. A judge will balance the needs of the employer against the harm to the employee. A judge will decide whether the geographic and time restrictions are appropriate to accomplish the employer’s needs, but no more. Further, a judge will consider whether there is any potential injury to the public if a restrictive covenant is enforced.

A judge will analyze the past court decisions in the state and compare the facts of those cases with the current case. Such facts include the size of the city or town the practice is in, the severity of the geographic and time restrictions in the clause, what the practice is like, the availability of other healthcare providers, and what the employment climate is like for healthcare providers.
Judges have found restrictive covenants unreasonable when the restraint is greater than necessary to protect the legitimate business interests of the employer. Judges also have found restrictive covenants unreasonable when the restraint is not greater than necessary to protect the business interests but the employer’s need for protection is outweighed by the hardship to the employee. Occasionally, judges have found restrictive covenants to be unreasonable when there is neither excessive restraint nor excessive hardship but there is a likely injury to the public. For example, a covenant restricting an oral surgeon from practicing in a particular city for 3 years after termination from a practice was found to be unreasonable. The restraint was greater than necessary. However, a covenant restricting a veterinarian from practicing in a different city for 3 years after termination was found to be reasonable. In that case, the restraint was not greater than necessary. In yet another case, a covenant restricting a physician from practicing in a rural town for 3 years after termination was found to be unreasonable. In that case, there was a potential injury to the public. The injury to the public was a potential shortage of physicians if one of the two town physicians could no longer practice there. The difference in outcome in these three cases can be
reconciled only by comparing the factual details of the cases. A decision that one clause was reasonable while a seemingly identical clause was unreasonable was due to differences in profession, practice, city, availability of other providers, and many other factors.

When negotiating the terms of a restrictive covenant, an NP needs to consider the circumstances of the job offer, the severity of the restriction, the potential hardship imposed on her or him by the covenant, the availability of healthcare providers in the area, and the availability of other practice opportunities.

In agreeing to a restrictive covenant, an NP is giving up something of value—the ability to take any other NP job that is offered to her or him. However, if an NP refuses to sign a reasonable restrictive covenant the employer may suspect the NP is looking to start a competing practice nearby. In some cases, when an NP job candidate refuses to sign a restrictive covenant, the employer rescinds the job offer. The best practice for restrictive covenants is to negotiate one the NP can live with, one that seems reasonable for all concerned under the particular circumstances of the practice and the NP. Exhibit
Exhibit 10-1 Restrictive Covenants

Restrictive covenants are enforceable if they balance:

- The employer’s need for protection
- Hardship to the employee
- Likelihood of injury to the public

**Example 1:** “Upon termination of employment for any reason, NP agrees not to practice in any location within 25 miles of any present or future office of this practice for a period of 5 years.”

**Analysis:** Accomplishes employer’s need for protection but may be broader than necessary to accomplish employer’s need and may put excessive hardship on employee to find alternative work 25 miles away.

**Example 2:** “Upon termination of employment for any reason, NP agrees not to practice in any location within 1 mile of the Jones Road office of this practice for a period of 1 year.”
**Analysis:** Not a hardship on employee but may not accomplish employer’s need for protection because patients may be willing to travel 1 mile to see the NP.

**Bonus Formulas**

Some employers offer NPs the opportunity for bonuses. The criteria for bonuses vary greatly. The two most important are that both employer and employee understand the formula and that it be consistent with good patient care.

The most common problem with bonus formulas is vague language. If a formula is vague, it is sure to be interpreted in different ways by different individuals. This can result in disagreements and disappointments at distribution time.

**Productivity-Based Formulas**

Many formulas are based on the number of patient visits per year. This makes good business sense under a fee-for-service system of reimbursement. If a practice is at least half fee-for-service, patient visit–based formulas can be a reasonable choice. Tracking patient visits is uncomplicated and not usually susceptible to vagueness. Generally, an NP who sees large numbers of patients is a productive employee who deserves a bonus.
Bonus formulas based on numbers of patient visits make less sense when reimbursement to the practice is capitated. Under a capitated system of reimbursement, a practice is paid a set fee per patient per month, regardless of the number of patient visits. Under capitated reimbursement, the ultimate goal is not a high number of visits from each patient but rather good patient care in as few visits as possible. Under capitated reimbursement, bonuses should be given to those providers who demonstrate high-quality care as evidenced by some documented quality measurement tool. Numbers of patient visits should not be relevant when a practice’s patients are capitated. Employers have to be careful not to give providers bonuses for withholding care. Aside from the moral and ethical problems involved, there are federal laws that prohibit healthcare providers from profiting by delivering inadequate or inappropriate care.

Many practices have a mix of fee arrangements with patients and payers. Employer and employee should plan for such mixes when devising a bonus formula. A bonus formula should fit the practice’s payer mix.

**Quality-Based Bonuses**
When more than half of patients are covered by some form of managed-care plan, NP performance can be rewarded on the basis of meeting or exceeding quality standards set by the health plan. For example, bonuses could be awarded when the percentage of patients who have met health maintenance criteria—such as childhood immunizations or mammograms for women over 50—exceeds 80%. Or bonuses could be awarded if emergency department visits declined in the past year.

While performance measures are more difficult to track than patient visits, they are more suited to managed care. Some health plans supply performance data to practices, and these data can be used to determine bonuses.

To track this kind of performance data and apportion bonuses based on performance, patients and primary care providers have to be paired. NPs need to have their own panels of patients and be designated as the primary care provider for that panel. Otherwise NP–physician teams have to work together and share bonuses.

**Profit-Based Formulas**
Some employers share profits with NPs. This can be satisfying to both employer and employee as long as the method for determining profits is clear.

NPs should be aware that there are accounting methods that can maximize or minimize profits and that profit is a word that has modifiers, such as *gross* and *net*, which can mean the difference between a bonus and no bonus. NPs who agree to profit-based formulas should negotiate for the right to audit financial records. NPs should also negotiate for a dispute-resolution process.

**Patient Satisfaction–Based Formulas**

Bonus formulas are one of the most controversial aspects of provider relationships. Many practices struggle with this issue. One approach taken by employers is to implement a bonus formula with the understanding that it can be altered and improved on each year. See **Exhibit 10-2** for some examples of bonus formulas that have been offered to NPs.

### Exhibit 10-2 Examples of Bonus Formulas for NPs’ Contracts

- Up to 15% of base salary: 5% if practice is profitable, 5% based on meeting a threshold of patient visits, and 5% based
on patient satisfaction, staff satisfaction, and citizenship

- The product of “collected billings” multiplied by “total employee billings” divided by “total practice billings,” with a cap
- A figure determined by a committee, based on meeting criteria for (1) financial performance; (2) quality of medical services determined by outcomes, medical appropriateness, and extent of health promotion services provided; and (3) level of patient satisfaction

**Termination Without Cause**

Typically, the termination section of an employment agreement will list events that are a basis for termination of the employee “with cause.” These events often include conviction of a felony, loss of license, loss of hospital privileges, and gross negligence that compromises patient safety.

In addition to termination-with-cause provisions, some employment agreements include a termination-without-cause clause, which states that an employer can terminate an employee at any time, without cause, with 30 days’ notice (see examples in Exhibit 10-3).
Exhibit 10-3 Examples of Termination Clauses

A Termination-with-Cause Clause

The employer may terminate this agreement at the sole discretion of the employer, by written notice to the NP, upon the occurrence of any of the following:

- The NP dies or becomes disabled
- The NP loses his or her professional license
- The NP is limited or restricted by any governmental authority having jurisdiction over the NP to the extent that the NP cannot render the required professional services

A Termination-Without-Cause Clause

The employer may terminate this agreement at any time, for any reason, after 30 days’ notice to NP.

NOTE: Not recommended for NPs, because a contract usually means the NP has job for the term of the contract, usually at least 1 year.
A termination-without-cause clause effectively defeats one of the purposes of a contract for an employee. An employee who can be terminated at any time for any reason or for no reason not only has no job security but also will think twice about pressing for performance of any of the other provisions in the employment agreement. For example, an NP may believe that a bonus was due, whereas the employer may believe that no bonus was due. If the NP protests too much, the employer can simply terminate the NP. If, on the other hand, an NP can be terminated only “for cause,” the NP will feel freer to be assertive about ensuring that the other provisions of the contract are fulfilled.

There are reasons to agree to a termination-without-cause clause, however. If an NP cannot commit to a full year’s employment, it may be best to agree to the without-cause clause. Most employers will not agree to delete a without-cause clause unless the employee also gives up the right to leave with just 30 days’ notice.

How to Negotiate a Reasonable Agreement
Preparing to Negotiate
NPs who have worked for years without contracts are now being offered contracts. NPs who are
currently working without contracts, foresee an offer in the future, and want to negotiate a satisfying contract will lay the groundwork a year in advance.

First, an NP should be able to state clearly what he or she has contributed to the practice in the past year and have supporting data. Specifically, the NP should have at hand the total number of patient visits and the dollars billed and received as a result of those visits. If an NP does administrative work, he or she should make a list of administrative projects and determine the dollar worth of the projects to the practice. The NP can contrast the revenues she or he has brought in with the expenses related to her or his practice, including salary, benefits, and continuing education. If there are patient satisfaction surveys or quality-of-care data that support the NP, the NP should have those data at hand. While new NPs will not have the option of collecting data in preparation for negotiating first contracts, they should find out everything they can about the practices with which they plan to negotiate. Once employed, new NPs should begin to collect data for future contract negotiations.

First, an NP needs to make the following assessments about his or her speed and comfort level:
How many patients can I see per hour, day, month, and year?

How much physician consultation time will I need from a physician at the practice: a 10-minute consultation on every patient, a 5-minute consultation once a day, or a 5-minute consultation once a year?

Second, an NP should gather basic information on how the practice gets its revenues. The NP should know which insurers pay for NP services and how much they pay. If the payer mix is likely to change in the coming year, the NP must be ready to explain how his or her value to the practice will continue to increase in the coming year. The NP can propose ways in which the practice can increase its efficiency and revenues in the coming year and offer to help implement plans. An NP embarking on a salary negotiation needs to gather the following data from her or his employer:

- What is the most frequently billed CPT (procedural) code for the practice? What amount does the practice bill and receive, on average, for that CPT code?
- What percentage of practice income goes to cover practice expenses? If the employer will not reveal that information, the NP can ask how many providers share practice overhead
expenses. A solo practitioner pays 43% of his or her income for office expenses, whereas a practice of 10 to 24 doctors pays 23.5% of their income for office expenses. Determine the appropriate rate to deduct for practice expenses.

- What is the collection rate for the practice?
  Remember, 90% is good. Any percentage below 90 is not.

Third, the NP should decide which terms of employment are essential and which can be given up. He or she should ask for everything he or she wants but be ready to back down on nonessential terms.

Fourth, the NP must anticipate any drawbacks that an employer might raise in negotiations and prepare to defend or minimize those drawbacks.

**Negotiating**
Generally, it is best to negotiate individually rather than as a member of a group. For a variety of reasons, some NPs will be more valuable than others to an employer. A more valuable NP should get better offers. On the other hand, some employers have a standard NP offer and will not deviate for an individual NP. In that case, NPs need to negotiate as a group.
Whether negotiating individually or as a group, an NP should read a proposed contract carefully, note areas that are confusing, and get clarification. NPs should remember that everything is negotiable. While a contract may look intimidating, it was typed on a word processor and can be changed.

NPs should seek legal counsel to review any proposed contracts.

**Getting Help: What to Look for in a Lawyer**

Negotiating is best done by the NP employee, but contract review is best done by an attorney. An attorney who is familiar with NP contracts and business issues is a good first choice. A second choice is an attorney who reviews contracts of other healthcare providers, physicians in particular.

NPs should avoid attorneys who need to research the law regarding NPs. One NP spent $1,500 for her attorney to research the law on NPs, only to find that she knew the answers to the questions he was looking up.

Attorneys charge between $150 and $1,000 an hour. Many will negotiate a flat fee for reviewing a contract. It is prudent to spend $400 for review of a
contract that is worth between $80,000 and $140,000 per year to an NP. If an attorney finds vague wording that needs to be made more specific, the investment in the attorney will be repaid in the long run.

**Understanding Business**

If an employer has a well-run, profitable practice to which an NP contributes significantly, the NP should expect to be rewarded well under an employment agreement. If a practice is losing money, no NP will be able to negotiate a satisfying agreement, no matter how excellent he or she is.

NPs are clinicians by nature, not businesspeople. However, all types of clinicians are increasingly finding that they need to understand more about the business of health care. An NP who understands the financial base for a practice is in a better position to negotiate a satisfactory employment agreement than an NP who knows only the clinical side of practice. An employer will respect an NP who approaches negotiations with attention to both business principles and patient care concerns.

**Negotiating Salary**

New NPs are notorious for asking only two questions of a new employer: (1) What does the
position pay? and (2) What are the benefits?

Four methods of payment are currently being used to pay employed NPs:

1. Straight salary
2. Percentage of net receipts
3. Base salary plus percentage
4. Hourly rate

In a straight salary arrangement, an NP is paid a set amount to perform according to a job description. In a percentage salary arrangement, an NP is paid the amount the NP bills minus accounts receivable, minus the NP’s portion of practice expenses (which includes the expense of physician consultation). In a base salary plus percentage arrangement, an NP is guaranteed a set salary but can make additional salary if he or she generates practice income over some set amount. NPs working on an hourly basis are paid only for the hours worked.

Straight salary and hourly are more commonly encountered arrangements than percentage or set salary plus percentage. The advantage of percentage-based salaries is the opportunity for productive NPs to have some control over their earnings. The disadvantage is that the method sets
up fellow providers in a practice as competitors for patients.

No matter what arrangement an NP chooses, it is wise to focus on hard figures that document an NP’s monetary contribution to a practice and the costs of the NP to the practice.

NPs bring in income on a fee-for-service basis or a per-member-per-month basis. Calculating an NP’s share of income for a fee-for-service practice is done by multiplying the number of visits by the collected fee per visit. When a practice’s patients are capitated, an NP’s share of income is calculated by multiplying the number of patients on an NP’s panel by the per-member-per-month fee coming into the practice.

The cost of maintaining an NP is calculated by adding together practice expenses and the cost of physician consultation. Practice expenses can be estimated or calculated for a particular practice. For a solo practice, expenses can be 40–50% of the income. For a large practice, expenses are lower, 20–30% of income. Practice expenses include rent, salaries, taxes and benefits of support staff, taxes and benefits of NPs, supplies, laboratory expenses, depreciation, car, continuing education, and
insurance (malpractice, workers’ compensation, and premises insurance).

An NP who needs a great deal of physician consultation should expect to compensate her or his employer physicians for their time. An NP who needs little consultation should command a higher salary because he or she needs little of a physician’s time. Until NPs no longer need a physician on written agreement, all NPs should expect to pay something for physician consultation. Experienced NPs often pay physician employers/consultants 10–15% of their net income brought to the practice.

Most employers will want a percentage of an NP’s earnings as profit. An experienced NP who needs little consultation from an employer physician might consider his or her contribution to profit to be the 10–15% of net income paid for consultation, as noted in the earlier paragraph. A newer NP should expect to contribute 10–15% of net earnings to an employer as profit in addition to 15–25% of net earnings for physician consultation.

To project an appropriate salary for a particular NP, follow these steps:
1. Calculate income to the practice based on NP billings.
2. Subtract 10% for unpaid bills.
3. Subtract:
   a. The calculated figure for practice expenses (20–50% of earnings)
   b. The cost of physician consultation (10–20% of net earnings)
   c. A percentage for employer profit

Fee-for-service practices.
For example, an NP who sees 15 patients per day at $70 per patient visit, on average, brings in $1,050 per day. Allowing 1 week off for continuing education, 1 week off for illness, and 4 weeks off for vacation, this NP potentially will bring in $241,500 a year. However, not all bills are paid. With a 90% collection rate—a reasonable collection rate for an efficient practice—this NP actually will bring in $217,350 per year. An NP who sees 24 patients per day will bring in $1,680 per day, or $386,400 per year, in accounts receivable. With a 90% collection rate, this NP will bring $347,760 to the practice.

Deducting 40% of the NP’s gross generated income for overhead expenses (rent, benefits, continuing education, supplies, malpractice, lab expenses, and depreciation of equipment) leaves $130,410 for the
15-patient-per-day NP and $208,656 for the 24-patient-per-day NP. Further deducted 15% of that figure to pay a physician for consultation services leaves $110,848 in salary for the 15-patient-per-day NP and $177,357 in salary for the 24-patient-per-day NP. Deducting 10% for employer profit leaves $99,763 in salary for the 15-patient-per-day NP and $159,621 for the 24-patient-per-day NP. Note that some practices are compensated more than $70 per visit, on average, and some less. Some practices have a collection rate that is less than 90%. Note also that some practices will be able to justify 50% of generated income for practice expenses and some practices will want more than 10% profit. Ultimately, the employer gets to make the final decision about these percentages. The NP’s options are to accept, negotiate something better, or find other employment.

**Capitated practices.**

*In a fully capitated practice, an NP who has a panel of 1,000 patients at an average fee per member per month of $10 will bring in $120,000 annually. There should be a 100% collection rate under a capitated system of reimbursement.*

Applying 40% to overhead leaves $72,000 for the NP’s salary, and paying 15% for physician
consultation and 10% for employer profit leaves $55,080 for the NP’s salary. An NP with a larger panel will make more.

**The new NP.**

A newly graduated NP without experience may be able to see only 10 patients a day, with four or five 10-minute physician consultations per day, for the first 6 months. Plugging in the figures from the earlier examples, the NP will bill 2,400 visits per year (2 weeks’ vacation for the new grad) at $70 per visit to total $168,000 in accounts receivable. With a 90% collection rate, the new NP will bring in $151,200.

Deducting 40% for practice expenses brings the net income to $90,720. Because a new NP often requires significant consultation time with a physician (or an experienced NP), an additional 25% ($22,680) is deducted for payment for consultation, bringing the NP’s salary down to $68,040. With a contribution to employer profit, this new NP’s appropriate salary is down to $61,236.

After 6 months, when the same NP becomes more comfortable and efficient, the income numbers should double, and consultation requirements should decrease so that the appropriate salary will
more closely approximate the salary of the 15-patient-per-day NP and eventually the 24-patient-per-day NP in the previous examples. Many employers start a new NP at a salary significantly higher than $61,236, expecting that low productivity in the first 6 months will be balanced by high productivity in the second 6 months.

There are experienced NPs who see more than 15 patients per day at CPT code level 99213 (established patient, mid-level visit) or higher who are not making the salary supported by the previous calculations. There are numerous reasons for this. First, the practice may expect more than 10% profit. Many employers expect to make a profit equal to an employee’s salary. Second, the NP may have higher expenses than normal. Third, the collections rate may be lower than 90%.

Are these projections accurate?

One could argue about whether the percentages used in the given examples are correct. In fact, some practices have poor rates of collection, some practices have higher overhead expenses, and some physicians want more payment for consultation. Some employers want more profit than projected here. However, an NP should not be subsidizing a poorly run practice and need not
agree to overcompensate a physician or employer. Many practices receive more than $70 per NP visit on average. In these practices, an NP’s salary should be proportionately higher.

**Reported median NP salaries.**
Comparing these calculated NP salaries with some of the recently reported median salaries for NP salaries is an interesting exercise. Some medical groups use the Medical Group Management Association’s (MGMA’s) median salary data. The salary range, depending on region, of an NP in 2014 was $90,000 to $102,000, according to the MGMA. ADVANCE for NPs & PAs reported in its 2014 salary survey that the median NP salary for 2014 was $101,621.

NPs should keep in mind that salary averages are based on surveys. There is no way of knowing whether the respondents are representative of NPs. NPs who believe they are worthy of higher salaries than surveys suggest should present all of the reasons why they deserve the figure they are seeking.

As in all negotiating, there are three things to remember:
1. One who does not ask will not receive.
2. One who does not deserve will not receive.
3. Even when one asks and deserves, one will need to do some selling to get what one wants.

**Negotiating Benefits**

There are three yardsticks by which to evaluate a benefits package:

1. What benefits does the NP need?
2. What is reasonable?
3. What are other NPs getting?

Only the first two count. It should not matter to either the NP or the employer what others are getting, only what the NP needs, wants, or deserves and what the employer can afford and is willing to cover.

An NP in the late stages of job interviewing should ask a prospective employer the following questions:

- What benefits usually are offered?
- Does the employer pay for continuing education?
- Is time away for continuing education paid time?
- What is the retirement plan?
What are the basics of the health plan? Is dental included? Is vision coverage included?
If calls are required, are a cellular telephone, a beeper, and car allowance included?
What vacation time is being offered?
How is sick time handled?
Is malpractice insurance paid by the employer? If so, will a separate attorney for the NP be covered? Is the policy occurrence or claims made?
Are relocation expenses paid?
Is there a sign-on bonus?
Are expenses of travel for the interview to be paid?
Does the employer pay for professional dues? If so, how much?
Does the employer pay for reference books and subscriptions to professional journals? If so, how much?
Are there any tuition reimbursement benefits for NPs or for dependents?
Is there a short- or long-term disability insurance benefit?
If travel to various sites is necessary, are automobile expenses reimbursed?

**Negotiating a Working Environment**
Of course, many nonmonetary aspects of an NP’s working life affect job satisfaction. An NP
contemplating a new job is advised to spend some time thinking about and perhaps listing both the aspects of former jobs that have been most satisfying and most frustrating. Then the NP can briefly summarize the best and the worst of former jobs with the prospective employer and try to maximize the positive in the new position. Here are some appropriate questions:

- Is on-call time required? If so, how are calls shared? What backup will an NP have if consultation is needed for a call?
- What kind of and how many support staff will the practice provide?
- What will support staff do for the NP? What will support staff expect the NP to do for them?
- To whom will the NP report about medical issues? Administrative issues? Payment issues?
- What continuous quality improvement methods does the practice use?
- If the NP finds some aspect of practice organization that he or she would like to change, what is the process for making suggestions?
- Is the NP expected to build a panel of patients or cover for overbookings of the other providers, or both?

**Interviewing**
A physician or administrator who is interested in hiring an NP may have significant, little, or no experience working with NPs. Therefore, NPs should be prepared to define NP scope of practice, list state requirements for collaboration or supervision, if any, and identify the sources of reimbursement for NP services.

In an interview for employment as an NP, a candidate should be prepared to answer the following questions:

- Why should I hire an NP?
- Why should I hire you?
- How many patients are you used to seeing in a day?
- Do you have a DEA [Drug Enforcement Administration] number?
- How independently are you used to practicing?
- What can you bring to the practice?
- What is your greatest job strength? Weakness?
- What can an NP legally do in this state?
- What do you want to be doing in 5 years? In 10 years?
- Does working evenings and/or weekends bother you?

**Responsibilities of an NP Employee**
Whether or not an NP has a contract, an NP has certain ethical responsibilities to her or his employer. These responsibilities include the following:

- Add to the goodwill an employer has built in the community by promoting the practice to the public
- Practice within the current standard of care
- Protect the employer’s “trade secrets,” such as patient mailing lists
- Provide one’s best customer service to patients of the employer
- Remain unimpaired by alcohol or drugs
- Maintain one’s credentials, knowledge of standard of care, and continuing education
- Maintain patient confidentiality

**Employer’s Evaluation of the NP’s Performance**

Some employers evaluate NP performance in highly structured ways—number of patients seen per month or quarter, income generated, detailed evaluation tools—and others use either no measure or very subjective measures.

An NP is advised to ask, in the interview stages, about the employer’s expectations for productivity, measures of quality, and other performance
measures. If an NP knows how his or her work will be evaluated, he or she has a better chance of meeting expectations. If there are no set methods of evaluation, an NP may want to offer to develop some standards.

**Malpractice Insurance**
The best malpractice policy for an NP is an occurrence policy, for at least $1 million per claim and $3 million aggregate, which covers the expense of an attorney for the NP as an individual. If an NP must purchase an individual policy to obtain this coverage, the NP should do so.

**Collaborative Practice Agreements**
In states where a collaborative agreement is required by law, the NP, the physician, or both are legally responsible for drafting and filing the agreement with the appropriate agency. The most prudent process for drafting a collaborative agreement is as follows:

- Collect information.
  1. *Review the state law regarding NP scope of practice*. Following are questions to be answered: Must the practice agreement be approved by the board of nursing and/or board of medicine prior to
beginning practice? Are there qualifications for the collaborating physician? Are there limitations on the collaborating physician (such as a limit on the number of NPs who may collaborate with the physician)? Is the practice agreement required solely for prescriptive authority or for any form of advanced practice?

2. **Determine the functions that the NP will supply to the proposed collaborative practice.** Will there be in-hospital care? Suturing? Surgical assistance? Prescription of controlled substances? Nursing home practice?

3. **Determine whether the physician collaborator’s area of specialty matches the NP’s.** Interview the physician collaborator, much as you would conduct a job interview, and check references. Ask whether there are any current or past malpractice cases against the physician or practice. Ask whether there has been any loss of hospital privileges or loss of Medicare participation.

- Draft an agreement for the collaborator’s review. Often, the board of nursing will have sample
written agreements on which an NP can base the draft.

- Finalize and submit the agreement. Sometimes the board of nursing will return an agreement with a request for more information. If so, simply redraft and resubmit.

An example of a practice agreement is given in Appendix 10-A. A sample employment agreement is provided in Appendix 10-B.
Appendix 10-A: Sample Nurse Practitioner Collaborative Practice Agreement from the Indiana Board of Nursing Template

Collaborative Practice Agreement for Advanced Practice Nurses Requesting Prescriptive Authority
Rule 848 IAC 5-1-1—Initial Authority to Prescribe Legend Drugs

1. Complete names, home and business addresses, zip codes, and telephone numbers of the licensed practitioner and the advanced practice nurse.

<table>
<thead>
<tr>
<th>Licensed Practitioner:</th>
<th>Advanced Practice Nurse:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed practitioner name and license number</td>
<td>Advanced practice nurse name and license number</td>
</tr>
<tr>
<td>Street address of home</td>
<td>Street address of home</td>
</tr>
<tr>
<td>City, state, and zipcode of home</td>
<td>City, state, and zipcode of home</td>
</tr>
</tbody>
</table>
2. **List of all locations where prescriptive authority is authorized by this agreement.**

3. **List all specialty or board certifications of the licensed practitioner and the advanced practice nurse.**

   Licensed practitioner is certified as a ___________ with a practice specialty in ___________. The advanced practice nurse is a nurse practitioner, clinical nurse specialist, certified nurse midwife, etc., with a specialized certification as a family nurse practitioner, etc.

4. **Briefly describe the specific manner of collaboration between the licensed practitioner and advanced practice nurse, specifically, how they will work together, how they will share practice trends and responsibilities, how they maintain**
geographic proximity, and how they will provide coverage during an absence, incapacity, infirmity, or emergency by the licensed practitioner. How they will work together: The licensed practitioner and advanced practice nurse shall collaborate on a continual basis, etc. How they will share practice trends and responsibilities: The advanced practice nurse shall make rounds at the request of the licensed practitioner and consult with the licensed practitioner as needed, etc. How they maintain geographic proximity: The licensed practitioner will maintain a physical presence within a reasonable geographic proximity to the advanced practice nurse’s practice location. How they will provide coverage during absence, incapacity, infirmity, or emergency by the licensed practitioner: In the case of the absence, incapacity, or unavailability of the licensed practitioner, coverage and consultation will be coordinated and maintained by another licensed practitioner as arranged in advance by the licensed practitioner and the advanced practice nurse.

5. Provide a description of limitations, if any, the licensed practitioner has placed on the
advanced practice nurse’s prescriptive authority. There are no additional limitations on the advanced practice nurse or there are the following limitations on the advanced practice nurse, etc.

6. **Provide a description of the time and manner of the licensed practitioner’s review of the advanced practice nurse’s prescribing practices.** Specifically, the description should include provisions that the advanced practice nurse must submit documentation of prescribing practices to the licensed practitioner within seven (7) days. Documentation of prescribing practices shall include, but not be limited to, at least a five percent (5%) random sampling of the charts and medications prescribed for patients. The advanced practice nurse must submit documentation of the advanced practice nurse’s prescribing practices within seven (7) days to the licensed practitioner for review. The documentation of prescribing practices shall include at least a 5% random sampling of the charts and medications prescribed for patients.

7. **Provide a list of all other written practice agreements of the licensed practitioner and advanced practice nurse.** There are no
other practice agreements or list all other practice agreements, etc.

8. **Provide the duration of the written practice agreement between the licensed practitioner and advanced practice nurse.** Either party may terminate this practice agreement without cause at any time, effective immediately upon notice to the other party, etc.

| ______________________________ | ______________________________ |
| Signature of licensed practitioner | Signature of advanced practice nurse |

| ______________________________ | ______________________________ |
| Date | Date |

To view a sample nurse practitioner collaborative practice agreement, please visit the Indiana State Board of Nursing website at the following address: [http://www.in.gov/pla/files/Sample_Collaborative_Practice_Agreement Updated(1).pdf](http://www.in.gov/pla/files/Sample_Collaborative_Practice_Agreement Updated(1).pdf)
Appendix 10-B: Sample Employment Agreement

NOTE: The following contract is suited for a particular NP and a particular medical practice. Other NPs and practices may need different or additional provisions. NPs and employers each should seek the counsel of an attorney for drafting a contract suitable to the needs of the particular parties.

Employment Agreement

THIS PROFESSIONAL SERVICES EMPLOYMENT AGREEMENT (the Agreement) made this __________ day of __________, 2017, by and between Jones Medical Clinic, a professional corporation in the State of Georgia, hereinafter referred to as “the Corporation,” and Jane Doe, MS, CRNP, an individual, hereinafter referred to as “the Nurse Practitioner.”

Recitals

The Corporation is a professional association formed in Georgia and engaged in the practice of
medicine. The services rendered by and on behalf of the Corporation are referred to as the Practice.

The Nurse Practitioner is licensed to practice in Georgia.

The Corporation desires to employ the Nurse Practitioner upon the terms and conditions hereinafter set forth, and the Nurse Practitioner desires to accept such employment.

**Article I—Employment**

1.1. Professional Services. The Corporation agrees to employ the Nurse Practitioner under this Agreement. The Nurse Practitioner agrees to render professional services for individuals who present themselves as patients of the Practice and to carry out the duties described in Schedule A, which is attached to and made a part of this Agreement. In performing such services, the Nurse Practitioner shall comply with policies and procedures established by the Corporation, including participation in quality assurance and utilization review activities. The Nurse Practitioner shall render professional services at the Jamestown location.
1.2. Full-Time Employment. The Nurse Practitioner agrees to devote her full-time and best efforts to the performance of the duties outlined in Schedule A attached to this Agreement.

1.3. Standards. The Nurse Practitioner shall exercise independent professional judgment with respect to the care and treatment of all patients. The Nurse Practitioner agrees that the patient care services will be provided promptly, efficiently, and in strict accordance with the ethical and professional standards for the provision of healthcare services adopted by the Practice. The Nurse Practitioner agrees that her patient care efficiency and productivity (for example, the number of outpatient visits per week) will be consistent with or better than past experience.

1.4. Authorization for Exchange of Information. The Nurse Practitioner authorizes the Corporation to obtain credentialing information from any necessary source. Credentialing information includes all information related to the Nurse Practitioner’s education, training, qualifications, character, and experience, including patient care, quality
assurance, utilization review, and risk management records.

1.5. Charges and Accounts Receivable. The Nurse Practitioner assigns to the Corporation the full right to bill for all professional, administrative, and clinical services performed by the Nurse Practitioner. The Nurse Practitioner agrees that all fees, when accrued or paid, are the sole property of the Corporation and that the Nurse Practitioner has no direct interest in any of these fees. All fee schedules shall be established by the Corporation.

1.6. Medical Records. All medical records of the Practice shall be the property of the Corporation, subject to applicable provisions of the medical records law of Georgia.

Article II—Compensation, Benefits, Disability, and Insurance

2.1. Nurse Practitioner Compensation. In consideration of the Nurse Practitioner rendering services under this Agreement, the Corporation will pay the Nurse Practitioner the compensation as set forth on Schedule B.

2.2. Vacation and Employee Benefits. In addition to the monetary compensation, the
Corporation shall provide the Nurse Practitioner with the vacation and employment benefits listed on Schedule C.

2.3. Termination of Disability. If the Agreement is terminated because of the Nurse Practitioner’s disability pursuant to Subsection 3.2.1, the Nurse Practitioner’s compensation shall terminate after the twenty-six (26) week determination period, but the Nurse Practitioner shall have the right to claim benefits under the long-term disability insurance policy provided as an employee benefit.

2.4. Professional Liability Insurance. During the term of this Agreement and thereafter, the Corporation shall continuously maintain in effect professional liability malpractice insurance for the Nurse Practitioner in the amount of $1,000,000 per occurrence/$3,000,000 annual aggregate coverage.

2.5. General Liability. During the term of this Agreement, the Corporation shall include the Nurse Practitioner as a covered employee under the Corporation’s general liability insurance policy.
Article III—Term and Termination

3.1. Term. The term of this Agreement shall be 1 year beginning __________, 2017, and, if not sooner terminated as provided below, ending __________, 2018. Thereafter, this Agreement shall automatically renew on a year-to-year basis, unless sooner terminated as provided below.

3.2. Termination by Corporation—Without Cure Period. The Corporation may terminate this Agreement at the sole discretion of the Corporation by written notice to the Nurse Practitioner (or representative) upon the occurrence of any of the following:

3.2.1. The Nurse Practitioner dies or becomes disabled. As used in this Agreement, disabled means the Nurse Practitioner’s inability to perform the material and essential functions of clinical care for patients, despite reasonable accommodations by the Corporation, by reason of any medically determinable physical or mental impairment that has been determined to be terminal or that has lasted or can be expected to last for a period of not less than twenty-six (26)
weeks, based on an examination by an independent physician selected by the Corporation.

3.2.2. The revocation, suspension, or cancellation of the Nurse Practitioner’s professional license.

3.2.3. The imposition of any restriction or limitation on the Nurse Practitioner by any governmental authority having jurisdiction over the Nurse Practitioner to the extent that the Nurse Practitioner cannot render the required professional services.

3.2.4. A final determination by any board, hospital, or other organization having jurisdiction over the Nurse Practitioner’s right to practice that the Nurse Practitioner has engaged in unprofessional or unethical conduct.

3.2.5. The Nurse Practitioner’s clinical privileges at a hospital are involuntarily reduced, suspended, or revoked by final action of the hospital board under the bylaws, rules, or regulations of the hospital.
3.2.6. The Nurse Practitioner is convicted in a criminal or civil proceeding of fraud, misappropriation, embezzlement, or Medicare or Medicaid fraud and abuse.

3.2.7. The Nurse Practitioner is excluded from participation in the Medicare or Medicaid program by reason of fraud and/or abuse.

3.2.8. The Nurse Practitioner has misused assets of the Corporation by fraud.

3.3. Termination by Corporation—With Cure Period. The Corporation may terminate this Agreement based upon a failure of the Nurse Practitioner to comply with the terms and provisions of the Agreement after giving the Nurse Practitioner a notice of the alleged deficiency and allowing the Nurse Practitioner thirty (30) days to cure the alleged deficiency. The following are examples of deficiencies subject to the provisions of this Section:

3.3.1. The failure or refusal of the Nurse Practitioner to comply with the reasonable policies, work requirements, standards, and
regulations of the Corporation that may be established from time to time.

3.3.2. The Nurse Practitioner breaches any obligation, covenant, or warranty under this Agreement, or the Nurse Practitioner fails to faithfully and diligently perform the services required by the provisions of this Agreement.

3.3.3. Notwithstanding the above, a 30-day notice shall not be required if the same deficiency has occurred more than twice in any 18-month period and written notice to cure was provided with respect to the previous occurrences, or if the deficiency is material and is incapable of being cured.

3.4. Termination by Nurse Practitioner. The Nurse Practitioner may terminate this Agreement:

3.4.1. Based upon a breach by the Corporation for failure to pay the compensation payable under the Agreement or failure to fulfill any other obligations under this Agreement, provided that the Corporation was
given written notice of default and thirty (30) days to cure the specified breach.

3.4.2. The physicians of the Corporation are convicted in a criminal or civil proceeding of fraud, misappropriation, embezzlement, or Medicare or Medicaid fraud and abuse.

3.4.3. The physicians of the Corporation are excluded from participation in the Medicare or Medicaid program by reason of fraud and/or abuse.

3.4.4. The Nurse Practitioner moves out of the State of Georgia and gives thirty (30) days’ notice.

3.5. Effect of Termination. Upon termination of this Agreement as provided in this Article III, neither party shall have any further rights, duties, or obligations under this Agreement, except as otherwise provided herein. The termination or expiration shall not affect any liability or other obligation of either party that accrued prior to the termination or expiration.

Article IV—Management Support Systems and Personnel
4.1. The Corporation shall provide for or secure nonphysician personnel (including administrative, nursing, and other medical support personnel) and services that are reasonably needed by the Practice consistent with sound management standards for similar practices in the community. These services shall include administration, marketing and financial services, computerized management information systems, and computerized billing systems.

4.2. The Corporation shall provide the Nurse Practitioner with monthly statements of billings, collections, and accounts receivable attributable to the Nurse Practitioner. Should the Nurse Practitioner have questions about the data supplied, the Corporation shall provide access to the Corporation’s accounting records and a clerk who keeps these records and will answer the Nurse Practitioner’s questions or supply further information as needed.

4.3. If the Nurse Practitioner’s own records of patient visits and billings differ from the records of the Corporation, and the discrepancy cannot be resolved by the information seeking covered by Section 4.2,
the Corporation agrees to designate one representative to negotiate a settlement acceptable to both parties within thirty (30) days. If no settlement can be reached internally, the Corporation agrees to submit any unresolved dispute to third-party arbitration, with the arbitrator selected from a list provided by the American Arbitration Association. The Corporation agrees to share equally with the Nurse Practitioner the expenses of arbitration.

4.4. The Corporation shall assign one physician to sign the Nurse Practitioner’s written agreement, as required by Georgia law. The physician assigned shall be available or shall appoint a designate who will be available for consultation with the Nurse Practitioner when needed.

Article V—Notices
All notices shall be in writing and personally delivered or sent by certified or registered mail, postage prepaid, return receipt requested, addressed to the Corporation and the Nurse Practitioner at the addresses shown below. Any and all notices or other communication given pursuant to this Agreement shall be deemed duly given on the date personally delivered or on the date deposited
in the U.S. Postal Service. The parties may change its or his or her address by specifying the change in a written notice to the other:

If to the Nurse Practitioner:

Jane Doe, CRNP
98 Merit Drive
Jamestown, GA 20000-3000

If to the Corporation:

Jack Frost, MD
201 Medical Drive, Suite 100
Jamestown, GA 20000-3000

Article VI—Miscellaneous

6.1. Entire Agreement. This Agreement embodies the entire agreement between the parties and supersedes all prior agreements, letters of intent, or understandings of any nature whatsoever between the parties with respect to the matters covered herein.

6.2. Amendment: Nonwaiver. Except as otherwise specifically provided, no amendment or modification of this Agreement
shall be valid unless it is in writing and signed by the Nurse Practitioner and the designee of the Corporation as named in Article V. No waiver of any of the provisions of this Agreement shall be valid unless it is in writing and signed by the party against whom it is sought to be enforced. Any waiver of breach of this Agreement shall not be considered to be a continuing waiver or consent to any subsequent breach on the part of either the Corporation or the Nurse Practitioner.

6.3. Counterparts. This Agreement may be executed in counterparts, and each counterpart shall be deemed an original.

6.4. Assignment. This Agreement may not be assigned by the Corporation to any entity without the prior written consent of the Nurse Practitioner. This Agreement is personal to the Nurse Practitioner and is not assignable by the Nurse Practitioner, in whole or in part, without the prior written consent of the Corporation. This Agreement is binding upon and inures to the benefit of the parties’ respective permitted successors and permitted assigns.

6.5. Governing Law. This Agreement shall be construed in accordance with and governed
by the laws of the State of Georgia.

6.6. Governmental Requirements. This Agreement is subject to the requirements of all applicable laws and regulations and any government agency having jurisdiction. The parties agree to negotiate in good faith to amend this Agreement to comply with any governmental requirements affecting the Agreement or either party, including, without limitation, requirements affecting reimbursement for healthcare services. If the parties are unable to negotiate a mutually acceptable amendment to comply with any provision of law, regulation, or ruling, either party may initiate a voluntary termination of this Agreement on thirty (30) days’ notice.

6.7. Confidentiality. The parties agree not to disclose this Agreement or its contents to any person, firm, or entity, except the agents or representatives of the parties, and except as required by law.

6.8. Further Assurances. The Nurse Practitioner agrees to execute, acknowledge, seal, and deliver further assurances, instruments, and documents and to take such further actions as the Corporation may
reasonably request in order to fulfill the intent of this Agreement.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed as of the day and year first above written, with the intent that this be a sealed instrument.

BY:

Jack Frost, MD
Jones Medical Clinic, PC
Date __________

Jane Doe, MS, CRNP
Date __________

WITNESS/ATTEST:

Date __________

Schedule A—Duties
1. The Nurse Practitioner shall provide clinical and professional medical services to patients within the scope of Nurse Practitioner’s qualifications and consistent with accepted standards of medical practice and consistent
with the reasonable productivity standards adopted by the Corporation and the Nurse Practitioner.

2. The Nurse Practitioner shall provide general patient care at the site specified by performance of accepted procedures and commonly used therapies and provision of appropriate support services. The Nurse Practitioner’s duties shall include, but not be limited to, keeping and maintaining (or causing to be kept and maintained) appropriate records relating to all professional services rendered by Nurse Practitioner under this Agreement and preparing and attending to, in connection with such services, all reports, claims, and correspondence necessary and appropriate in the circumstances, all of which records, reports, claims, and correspondence shall belong to the Corporation. The Nurse Practitioner shall do all things reasonably desirable to maintain and improve her or his professional skills, including attendance at professional, postgraduate seminars and participation in professional societies. In addition, the Nurse Practitioner shall perform the following administrative, teaching, or professional services for the Corporation:
a. Order medical supplies for the office.

b. Review lab and radiology reports of office patients, and take appropriate follow-up action.

c. Precept students from Georgia State University.

3. The Nurse Practitioner shall be responsible for the quality of medical care rendered by Nurse Practitioner to the patients of the Practice and for ensuring that such care meets or exceeds currently accepted standards of medical competence.

4. The Nurse Practitioner shall participate in the quality assurance and risk management program.

5. The Nurse Practitioner shall assist in the recruitment and hiring of professional personnel and support staff to work in the Practice.

6. The Nurse Practitioner will relate to colleagues, staff, patients, and the public in a collegial manner and will abide by standards of conduct appropriate to the workplace.

7. The Nurse Practitioner shall assist in the marketing of the Practice and participate in the professional activities that promote the Practice.
Schedule B—Compensation

1. During the year of this Agreement (__________, 2017 to __________, 2018), the Nurse Practitioner shall be paid a salary of $91,000, payable in biweekly installments. Salary is understood to include the Nurse Practitioner’s share of collected billings, as determined in Paragraph 2 below, and the Nurse Practitioner’s performance of administrative, teaching, and other professional duties as specified in Schedule A, Paragraph 2, previously listed.

2. Billings shall be apportioned as the Nurse Practitioner’s share as follows:
   
   a. The Corporation and the Nurse Practitioner agree that efficiency at collections is outside of the control of the Nurse Practitioner, but within the control of the Corporation. Therefore, the Corporation and the Nurse Practitioner agree to apply a 95% collection rate (percentage of billings collected, as of 120 days after billing) for the purposes of determining the Nurse Practitioner’s collected billings. The Corporation agrees to take responsibility for maintaining a 95% rate of billings collected. In the event
that the Corporation does not collect
95% of its billings during the term of
this Agreement, Corporation agrees to
pay the Nurse Practitioner salary as if
the Corporation had maintained a 95%
collections rate.

b. The Corporation and the Nurse
Practitioner agree to a fee schedule for
the Nurse Practitioner’s services, which
is attached.

3. The Nurse Practitioner agrees to bill a
minimum of $270,000 per year.
   a. Billings shall include self-paying
      patients, third-party payers, and
      internal billings, which shall include
      surgical follow-up visits handled by the
      Nurse Practitioner for the Corporation.
   b. Surgical follow-up visits are assigned a
      value of $70.00.

4. The Corporation shall retain all but $91,000 of
collected revenues from the first $270,000 of
billings generated by the Nurse Practitioner.

5. The Nurse Practitioner shall receive bonus
payments to be determined as follows:
   a. If the Nurse Practitioner’s billings
      exceed $68,000 in any quarter,
collected revenues exceeding $68,000 per quarter shall be shared jointly and equally by the Nurse Practitioner and the Corporation, and the Corporation shall pay the Nurse Practitioner’s 50% share to the Nurse Practitioner as a bonus within 30 days of the last day of the quarter.

b. If the Nurse Practitioner bills less than $68,000 in any quarter, the Nurse Practitioner shall receive no bonus for that quarter, and the difference between the amount billed by the Nurse Practitioner in the deficient quarter and $68,000 shall be deducted from any bonus the Nurse Practitioner shall receive in a future quarter. There shall be no deduction from the Nurse Practitioner’s salary.

c. In the event that this Agreement is terminated prior to receipt of any bonus payment due the Nurse Practitioner, the Corporation agrees to pay the Nurse Practitioner the bonus earned within 15 days of termination. In the event that termination occurs mid-quarter, both parties agree that neither
bonus nor deficiency will apply for the final quarter.

**Schedule C—Benefits**

1. The Nurse Practitioner shall be entitled to the following benefits:
   a. Health insurance: The Corporation shall pay directly to the health insurance company up to $5,000 per year for premiums for health insurance.
   b. Malpractice insurance: The Corporation shall pay the malpractice insurance premiums for the Nurse Practitioner.
   c. Pension benefits: The Corporation will fund the Nurse Practitioner’s pension benefits.
   d. Vacation: Four (4) weeks per year.
   e. Continuing medical education time: One (1) week.
   f. Continuing medical education expenses: Up to $1,500.00 per year, paid for by the Corporation.
   g. Life insurance: In an amount equal to annual base salary.
   h. Salary continuation plan: Short-Term Disability—full pay continuation until Long-Term Disability coverage begins at ninety (90) days.
i. Sick leave: Ten (10) days per year.

j. Professional fees and medical staff dues: Professional journals in the amount of $350 per year, medical staff dues at hospitals where the Nurse Practitioner attends patients of the Practice, state license fee, state Controlled Dangerous Substances and DEA license fees, and Basic Cardiac Life Support/Advanced Cardiac Life Support recertification fees.
Chapter 11: Practice Ownership: Legal and Business Considerations for the Nurse Practitioner Owner

Some state laws are more conducive to nurse practitioner (NP) practice ownership than others because of collaboration requirements, or lack thereof, and reimbursement practices. Nevertheless, NPs are starting their own practices, and many others have owned practices for over 25 years, hiring physicians where necessary to conform to the law.

The NPs who have been in practice for more than 25 years often bought an existing practice from a physician. In such cases, the NP was initially an employee or partner of the physician, and the physician opted to leave the area and sold the practice to the NP. In that situation, the NP had to
make many adjustments, but he or she did not have to start from scratch.

In the past 20 years, most NPs who have started practices have built their practices from the ground up. Some of these have started faculty practices associated with nursing schools. Others have been strictly private entrepreneurs.

As this edition is being written, there are proposals and plans for changes to the nation’s healthcare delivery system. It is impossible to predict how these changes will affect the landscape for NPs who want to start their own practices. Those considering practice start-up should be monitoring the state and national news to gain perspective on how their business ideas fit into their state’s and the nation’s plans.

**Advantages of Practice Ownership**

Even without a general redesign of health care, NPs who wish to run their own practices have been able to do so in many states. The advantages to an NP of practice ownership are as follows:

- The NP decides on the length of patient visits.
- The NP decides how the practice is run.
- The NP chooses employees.
The NP controls quality.
The NP controls referrals.
The NP may titrate workload to income.
The NP keeps profits.

There are also advantages for the public when NPs own practices:

- The patient gets the benefit of combined nursing and medicine.
- The patient gets more face time with the provider.
- The patient may pay less or get more for the same amount of money.
- The patient may have better access to healthcare.

In an NP practice, physicians are called in when necessary, but not all patients have to pay for a physician visit or wait for a physician to be available when a nurse could fulfill the patient’s needs.

**Examples of NP Practices**

NPs own the following types of practices:

- Travel medicine clinics
- Pediatric primary care
- Wound care consultations
- Home visits
- Family health centers
Urgent care
Cosmetic procedures

Barriers
It is true that NPs have more obstacles to overcome than physicians when starting a practice. These include the following:

- Getting on commercial insurance provider panels
- Getting and keeping a collaborating physician, if required by state law or if billing Medicare
- Getting referrals from hospital emergency rooms
- Getting privileges at hospitals
- Lack of legal authority to admit patients to nursing homes, order home care, or direct hospice services

This chapter is for the NP who has started a practice or who has considered or may in the future consider opening an NP practice and requires an understanding of the legalities and knowledge of the details involved. Appendix 11-A offers a checklist of considerations relevant to opening a practice.

Decisions Before Starting a Practice
There are 10 major business considerations when starting a practice:
1. With whom will I practice?
2. Where will reimbursement come from?
3. Will reimbursement cover expenses?
4. How will I get patients to come to the practice?
5. Where will the practice be located?
6. If the state requires a collaborative agreement, how will that be handled?
7. What sort of quality and productivity measures will the practice institute?
8. How will patient flow be handled?
9. Will the practice use an electronic medical record, and if so, which one?
10. Where will I get malpractice insurance?

Also important, though somewhat less important than the eight major considerations, are the following considerations:

1. What form will the business take?
2. What systems need to be set up for getting supplies and equipment and repairs, depositing cash, and disposing of hazardous waste?
3. Who will the practice hire to help?

With Whom Will I Practice?
There are advantages to both solo practice and group practice. Advantages of solo practice include:

- Autonomy
- Efficiency of one-person decision making
- Less income necessary to support one person than multiple people
- No chance that another person’s lack of productivity will affect one’s business
- No one can fire the NP

Advantages of group practice include:

- Possible greater access to capital
- Possible shared call and office coverage
- Another source of expertise
- Social support
- Possible economies of scale

There are many potential partners for NPs and many ways of aligning practices. In addition to the traditional solo practitioner or group practice of professionals, where patients come to the office and providers collect from insurance companies, there are hospital-affiliated practices, nursing home–based practices, employer-affiliated practices, and agency-affiliated practices.

**Where Will Reimbursement Come From?**
Reimbursement might come from any or all of five sources:

1. Government payers: Medicaid and Medicare
2. Private insurers: health maintenance organizations (HMOs), managed-care organizations (MCOs), and indemnity insurers
3. Patients who pay their own bills
4. Contracts
5. Grants

Reimbursement for NP services is discussed in more detail elsewhere in the text.

A practice owner should look into any and all sources of reimbursement. For example, some government and private agencies will contract with healthcare providers for health services. A pediatric NP might contract with the county school system to give immunizations or conduct school physicals. Certain procedures and diagnostic testing can be billed separately from visits, and a potential practice owner will want to see what opportunities there are for getting that income.

**Will Reimbursement Cover Expenses?**

Practice Expenses: Crunching the
Numbers

Many an employed NP has thought, “If I were in charge, I would never run the practice like this.” Before going too far with this line of thought, an NP considering opening a practice, and even an NP who expects to remain employed, needs to know how the numbers crunch in the business of primary care. Simply put, it takes a large number of patient visits to support a practice.

It costs at least $200,000 a year to run a primary care physician practice, not including physician compensation. Expenses include the following:

- Rent
- Payroll and employee benefits
- Quarterly state and federal taxes
- Office equipment
- Telephone and Internet connection
- Utilities
- Answering service
- Supplies
- Hazardous waste disposal
- Payment on start-up loan
- Professional dues and subscriptions
- Fee to register lab with federal and state governments
- Accounting fees
- Attorney fees
- Business travel (local—to nursing homes, patients’ homes, educational seminars—and also for continuing education)
- Gifts to staff
- Cleaning
- Insurance (professional liability, umbrella policy, workers’ compensation, unemployment)
- Application fee for hospital privileges
- Beeper and cellular telephone
- Advertising

**Office expenses.**
In addition to equipment, office expenses can include lab expenses, the lease of a car used only for business, depreciation of equipment, equipment rental, equipment maintenance, and continuing education tuition.

**Compensation and charges.**
Primary care physicians earn, on average, about $200,000 per year, according to several recent surveys. Keep in mind that physicians in private practice take as compensation the difference between income and expenses. How they apportion this compensation—retirement, health insurance, vacation pay—is up to them.
For the sake of illustration, assume the average cost of running a solo primary care physician practice is $550,000 per year: $300,000 in expenses and $250,000 in physician compensation. To cover salary and expenses, a physician has to conduct 5,500 patient visits a year at a charge of $100 per visit. This assumes that payment is received for each visit. In reality, not all bills are paid.

NP Practice Compared
Now, let’s run the numbers for a practice where the owner/provider is an NP. Assume that the NP pays a physician to be the collaborator on a written agreement required by state law. An NP practice will have all of the same office expenses, plus the expense of paying the physician who signs the NP’s written agreement. Malpractice insurance costs considerably less for an NP than for a physician, but the cost to cover a practice is $3,000 to $5,000 a year. Thus, for the sake of this example, assume the expenses are equal for an NP and a physician.

Reasonable NP compensation, considering the responsibility of a private practice, would be at least $100,000 per year. The total expense of running an NP practice, based on these projections, would be about $385,000.
Assume 4,500 patient visits a year, which translates to a daily load of 19 to 20 patients, 5 days a week, 47 weeks a year. An NP could charge $85, on average, per visit and make the salary and expenses listed earlier. If an NP charged less than $85 per visit, he or she would have to (1) take less compensation; (2) pay less for office, supplies, and so on; (3) have fewer office personnel than the average physician; (4) see more than 20 patients per day, 5 days a week; or (5) work more than 5 days a week, 47 weeks a year.

Twenty patients a day is a fairly reasonable load, but that volume and $85 per visit may not be attainable. More than 20 patients a day, every day, is a taxing patient load. That is not counting the time it takes to return telephone calls, deal with personnel problems, do payroll, and so on.

Still, the economics are favorable for NPs who want to be their own bosses, and they may not be working any harder than employee NPs. Those NPs who work for someone else are usually expected to see about 20 patients a day, but it will be someone else’s decision that they do so. And the majority of employed NPs will not make $100,000 per year.
For examples of a comparison between practice expenses and revenues of a physician practice and those of an NP practice, see Exhibit 11-1 and Exhibit 11-2. Exhibit 11-1 demonstrates that an NP practice could be run on approximately $150,000 less per year than a physician practice, largely because of the differential in salaries between NPs and physicians.

EXHIBIT 11-1 Primary Care Practice Expenses (in Dollars): NP Versus MD

<table>
<thead>
<tr>
<th>NP Practice Expenses</th>
<th>MD Practice Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent</td>
<td>20,700</td>
</tr>
<tr>
<td>Utilities</td>
<td>7,400</td>
</tr>
<tr>
<td>Supplies</td>
<td>25,300</td>
</tr>
<tr>
<td>Depreciation</td>
<td>3,400</td>
</tr>
<tr>
<td>Equipment rental</td>
<td>3,500</td>
</tr>
<tr>
<td>Equipment maintenance</td>
<td>2,300</td>
</tr>
<tr>
<td>Continuing education</td>
<td>1,600</td>
</tr>
<tr>
<td>Advertising/promotion</td>
<td>1,700</td>
</tr>
<tr>
<td>Expense</td>
<td>NP</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Cleaning</td>
<td>10,000</td>
</tr>
<tr>
<td>Insurance</td>
<td>4,000</td>
</tr>
<tr>
<td>Answering service</td>
<td>4,500</td>
</tr>
<tr>
<td>Licenses</td>
<td>1,200</td>
</tr>
<tr>
<td>Car</td>
<td>2,000</td>
</tr>
<tr>
<td>Legal</td>
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</tr>
<tr>
<td>Lab</td>
<td>7,900</td>
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<tr>
<td>Dues</td>
<td>600</td>
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<tr>
<td>Taxes</td>
<td>14,000</td>
</tr>
<tr>
<td>Other expenses</td>
<td>3,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>114,100</td>
</tr>
</tbody>
</table>

**NP Practice Salaries**

- NP, 1.0 FTE: $102,600
- LPN or RN, 1.0 FTE: $45,000
- Business manager, 0.5 FTE: $25,000
- Receptionist, 1.0 FTE: $35,000
- MD consultant: $10,000

**MD Practice Salaries**

- MD, 1.0 FTE: $225,000
- LPN or RN, 1.0 FTE: $45,000
- Business manager, 0.5 FTE: $25,000
- Receptionist, 1.0 FTE: $35,000
- MD consultant: $330,000
EXHIBIT 11-2 Primary Care Practice Revenues: NP or MD

Assumptions

Practice size: 3,000

Office hours: 40 hours per week

Number of visits per year: 4,700

Included Services

Healthcare maintenance and preventive care, all episodic visits including primary care gynecology, primary care, suturing, nebulization of asthmatics, skin biopsies, incisions and drainages, 24-hour on-call, venipuncture, lab services as allowed under CLIA (Clinical Laboratory Improvement Amendments) exemption
Excluded Services

Diagnostic labs other than CLIA exempt, pharmacy, emergency department visits, outpatient detoxification, home visits, mental health other than primary care, physical therapy, obstetrics, emergency transport, patient transportation, hospitalization, medical specialist care, surgery, chemotherapy, sigmoidoscopy, fracture repair

<table>
<thead>
<tr>
<th>Average Collection per Visit*</th>
<th>Yearly Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>$75</td>
<td>$352,500</td>
</tr>
<tr>
<td>$100</td>
<td>$470,000</td>
</tr>
<tr>
<td>$125</td>
<td>$587,500</td>
</tr>
<tr>
<td>$150</td>
<td>$705,000</td>
</tr>
</tbody>
</table>

*Average collection per visit would include the charge for the office visit, any lab tests done in the office, and any billable procedures or therapies performed.

How Will I Get Patients to Come to the Practice?
An NP who starts a new practice, as opposed to buying an established practice, will need to bring in
patients with whom the NP has already established a relationship or attract new patients. Either way, there are costs involved.

If an NP has signed an employment contract with a previous employer in which the NP has agreed not to compete with the previous practice under specified conditions, the NP must honor the agreement or face the possibility of a lawsuit. If the NP has not signed such a noncompete clause, then the NP is legally free to take established patients to his or her own practice. However, the previous employer, who has lost patients, is quite likely to be upset, and this nonmonetary “cost” is certainly worth considering.

Whether the NP is seeking new or old patients, some marketing efforts will be necessary. Marketing can take the form of word of mouth, letters, flyers, advertisements, health fair appearances, speaking engagements, television appearances, radio announcements or talk shows, social media, web pages, or newspaper articles. For more information on marketing, see Chapter 13.

Through marketing the practice, potential patients learn what services it provides and the advantages of visiting. Advantages of a particular practice to a
patient may be convenient location, free parking, ease of getting an appointment, acceptance of the patient’s insurance, an especially personable provider, extraordinary personal attention, or a reduced fee for cash-paying patients.

Some general principles of practice marketing include the following:

- The marketing message must be repeated many times—some say 12, some say 27—before a person learns it.
- Create a sense of affiliation with the practice.
- Create an image for the practice and a marketing message.
- Strive to exceed the patient’s expectations, and the patient not only will stay with the practice but also will tell others about it.
- A new patient is worth the price of a visit; a patient kept is worth thousands of dollars.

Where Will the Practice Be Located?
The location of the practice will determine how easy or difficult it is for patients to come. If the patient base that the NP is looking for is using public transportation or traveling on foot, then the practice must be on a bus line or in a neighborhood. If it is an inner-city practice but the patients are coming by
car, then convenient and inexpensive parking is a consideration. If a practice is looking for walk-in traffic, then a storefront location would be better than a second-story office in a large building.

Location also can have implications for practice income. In rural areas, there could be more opportunity due to less competition. On the other hand, there could be too few patients to support a practice. In certain urban areas, there is actually a dearth of healthcare providers, whereas in other urban and suburban areas, there is an oversupply. A study of locations of other providers is a prerequisite for choice of practice location.

**If the State Requires a Collaborative Agreement, How Will It Be Handled?**

If a collaborative agreement is required by state law, a practice will need to find a collaborator before opening.

The first step is to find out what the state law requires in the way of physician collaboration. Is it a signature on a written agreement and an agreement to consult when necessary, or is it more involved, such as quarterly review of charts, cosignatures on charts and prescriptions, and monthly meetings?
The second step is to make a list of possible collaborators. NPs will want to look for a collaborator who is competent, has a similar philosophy of patient care, will be accessible when necessary, and will do what is needed for a reasonable price.

The third step is to discuss the NP’s needs, the state’s requirements, and fees with the potential collaborator(s). Many potential collaborators are worried about increasing their liability for malpractice suits if they collaborate with an NP. Therefore, an NP may want to suggest that potential collaborators discuss any such increased liability with their malpractice insurer. If a physician’s premiums will go up, then that cost will have to be borne by the NP.

The fourth step is to weigh the potential contributions and expense of various possible collaborators.

The fifth step is to draft, or have an attorney draft, a professional services contract between the physician collaborator and the NP. If there are few willing and available collaborating physicians in the area, then a practice’s longevity is threatened if a collaborator bows out after the practice has opened.
Therefore, it is wise to hire a collaborator and seal the arrangement with a written contract with a term of at least 1 year and 60 days’ notice before the collaborator terminates the relationship. See Appendix 11-B for an example of an NP–collaborator agreement.

Finally, draft the written agreement as required by state law. If written practice protocols or guidelines are required by law, obviously those must be drafted also.

**What Sort of Quality and Productivity Measures Will the Practice Institute?**

If quality measures and systems to collect data on performance are set up at the time a practice opens, then data collection will proceed from day one, and attention to quality will be built into the structure of the practice.

At what sort of quality and productivity measures should a practice look? Practices will be interested in quantity—productivity—because the practice must do enough business to cover costs. Practices will be equally interested in high-quality clinical care so they can build their reputation for quality, satisfy patients, and avoid medical errors. And under a
revised payment system contemplated by Medicare (as of the time of the revision of this book), providers will be rewarded financially for meeting certain quality-based performance and outcomes measures.

Productivity
Productivity directly affects income. In a fee-for-service system of reimbursement, the more visits made and billed for, the more a practice makes. In a capitated system of reimbursement, the more patients enrolled with a practice, the more monthly fees the practice receives and the more patients potentially will need attention. Providers and staff who generate lots of work should be rewarded accordingly, and providers and staff who generate little work should be encouraged to be more productive.

Therefore, a prudent practice owner will build systems for tracking productivity into a practice from day one. Most software systems for practices track provider productivity. As for office staff productivity, measures should be agreed to by staff members and practice administrators at the time of hiring, with periodic review and revision of the standards that are set.
Clinical Performance
A good start when attempting to measure clinical performance is the Healthplan Employer Data and Information Set (HEDIS) put out by the National Committee on Quality Assurance (NCQA). Because NCQA audits health plans and health plans audit practices to collect data to submit to HEDIS, the HEDIS measures are becoming the industry-wide standards for comparing quality among providers.

Another source to review when thinking about measuring clinical performance is Medicare’s Physician Quality Reporting System (PQRS). As of the time this book is being revised, Medicare is proposing a slightly improved version: Merit-Based Incentive Payment System (MIPS). Information on these programs is available through Medicare’s website (http://www.cms.hhs.gov). If a practice will be seeing Medicare patients, it makes sense to incorporate participation in the PQRS or MIPS from the day it opens.

In addition, new practice owners will want to take part in electronic prescribing not only as a quality improvement and quality maintenance measure but also to take advantage of payment incentives, if available. (Medicare’s payment incentives for quality-based programs change from year to year,
so it is important for someone considering practice ownership to visit www.cms.hhs.gov prior to opening to determine the requirements and opportunities for the coming years.) Medicare’s Electronic Prescribing (eRx) Incentive Program is a reporting program that uses a combination of incentive payments and payment adjustments to encourage electronic prescribing by eligible professionals. The program provided an incentive payment to practices with eligible professionals (identified on claims by their individual National Provider Identifier and Tax Identification Number) who successfully e-prescribed for covered Physician Fee Schedule services furnished to Medicare Part B Fee-for-Service beneficiaries. The program also applied a payment adjustment to those eligible professionals who were not successful electronic prescribers on their Medicare Part B services.

**How Will Patient Flow Be Handled?**
From day one, there must be an agreed upon way of setting up appointments, greeting patients, getting insurance or other payment information, obtaining clinical intake information (e.g., history, old records, chief complaint, vital signs), visiting the provider(s), and arranging follow-up as needed.
Appointments
Appointment-making software is available. Appointment books from office supply stores remain a good option as well.

Payment Intake Information
For each patient, the intake staff person will need to obtain the following information:

- Name
- Address
- Telephone number
- Social Security number
- Date of birth
- Method of payment: insurance, cash, credit card
- Insurance company name, address, and telephone number
- Copy of insurance card
- Emergency contact name, address, and telephone number

For each new patient, the intake staff will need to provide the patient with the practice’s privacy policy and obtain the contact information the patient wants used for future communications.

Clinical Intake Information
A practice should have a clinical intake form—a history and physical form—suited to the patient. An
example of such a form for the college-age patient is included as **Exhibit 11-3**.

**Provider Visits**
A system for dealing with patient flow should address the following questions:

- Does the provider see one patient at a time or work multiple rooms?
- Does the provider get the patient from the waiting room or does an assistant get the patient into the examination room?
- Does the provider talk to the patient while the patient is dressed or does an assistant get the patient into a gown prior to the arrival of the provider?
- Does the provider chart and make telephone calls in a separate office or is the provider’s office space within the exam rooms?
- When the provider is finished, who takes care of ordering referrals and laboratory tests?
- Does the provider do all of the history taking and teaching or will registered nurses do these things?

**EXHIBIT 11-3 New Patient History**

<table>
<thead>
<tr>
<th>Family History</th>
</tr>
</thead>
</table>
State any blood relative, including parents, grandparents, and siblings, who have/had any of the following:

Alcoholism

Asthma

Cancer or leukemia

Infectious disease

State disease

High blood pressure

Kidney disease

Heart disease

Diabetes

Tuberculosis
Stroke __________________
Epilepsy/seizure __________________
Bleeding disorder __________________
Psychiatric illness __________________
Other familial disease __________________

**Personal Health History**

Give the approximate age at which you had any of the following:

- Chicken pox ____________
- German measles ____________
- Measles ____________
- Malaria ____________
- Mumps ____________
- Rheumatic fever ____________
- Meningitis ____________
- Tuberculosis ____________
- Asthma ____________
Allergies
Hay fever
Pneumonia
Pleurisy
HIV infection
Tonsillitis
Diabetes
Kidney disease
Thyroid disease
Concussion
Seizures
Bleeding disorder
Fainting
Migraine
Mental illness
Attention deficit disorder
High cholesterol
Diarrhea, chronic
Hernia
Overweight ____________
Joint injury/disease ____________
Gonorrhea ____________
Syphilis ____________
Herpes ____________
Other infectious disease ____________
Heart murmur ____________
Heart disease ____________
Circulatory problems ____________

Hospitalizations for injury, illness, surgery, or diagnostic testing:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
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</tbody>
</table>

Females: Menstrual History

Age of onset_______ Interval _______
Duration_________

Current menstrual problems, if any
_______________
Contraceptive method, if any
________________

Date of most recent Pap smear
________________________ Normal? Yes ______ No ______

Date of most recent mammogram
________________________ Normal? Yes ______ No ______

Please rank the following by circling severity in the last 3 years: 0 for absent, and 1, 2, 3 for increasing severity or frequency.

<table>
<thead>
<tr>
<th>Condition</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy injection</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back trouble</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood in urine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blurred vision</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boils</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Chest pain</td>
<td></td>
<td></td>
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<tr>
<td>Chronic cough</td>
<td></td>
<td></td>
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<tr>
<td>Constipation</td>
<td></td>
<td></td>
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<tr>
<td>Condition</td>
<td>Scale</td>
<td></td>
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<td>-------------------------------</td>
<td>-------</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Depression</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Difficulty concentrating</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty or pain swallowing</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty making friends</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discord with parents, spouse</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic violence</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Earaches</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fainting spells</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent urination</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health worries</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart racing</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
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<tr>
<td>Indigestion</td>
<td>0 1 2 3</td>
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<tr>
<td>Lack of energy</td>
<td>0 1 2 3</td>
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<tr>
<td>Loss of hearing</td>
<td>0 1 2 3</td>
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</tr>
<tr>
<td>Condition</td>
<td>Score</td>
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<td>-------------------------</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nightmares</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual problems</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short of breath</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinus trouble</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin problems</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleeplessness</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleepwalking</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sore throat</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stuttering</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tension</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble falling asleep</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of laxatives</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

When did you last see your dentist for an oral exam? _________________________
Do you smoke? If so, what and how much? ____________________________

How much alcohol do you drink? ____________________________

Have people annoyed you by criticizing your drinking? ____________________________

Have you ever felt bad or guilty about your drinking? ____________________________

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? ____________________________

Are you using street drugs? If yes, specify drug(s). ____________________________

Have you used street drugs in the past 2 years? If yes, specify drug(s). ____________________________

A positive answer to any of the previous seven questions is highly indicative of having an alcohol or drug problem. You are invited to discuss your answers with the nurse practitioner or physician.

Do you have an eating disorder? ______

Type?
Are you allergic to cats, dust, trees, grass, or other substances in the environment? 
______ If so, what?

If you are ALLERGIC TO ANY MEDICINE, please list here.
_________________________

Has your physical activity been restricted during the past 5 years?
_________________________

Give reason and explanation.
_________________________

Do you have any physical or emotional disability that interferes with your daily activities? If so, detail.
_________________________

Have you been physically violent with yourself or others? Yes _____ No ______

If so, detail. _________________________

Have you consulted a primary care provider recently for any illness or health problem? If so, detail. _________________________

Have you consulted a psychiatrist or psychologist in the last 2 years? If yes, for how long? Please provide the name,
address, and telephone number of your therapist. _________________________

Previous primary care provider’s name, address, and telephone number. 
________________________

Do you take any medication regularly? 
______ If so, what? 
________________________

IMMUNIZATION RECORD

Tetanus booster within 10 years. Date ___/ ___/

Measles vaccine, two doses required after 12 months of age.
Dose 1. Date ___/ ___/ Dose 2. Date ___/ ___/

Mumps, one dose required. Date ___/ ___/

Rubella, one dose required. Date ___/ ___/

Diphtheria. Date ___/ ___/

Pertussus. Date ___/ ___/

Polio. Date ___/ ___/

Pneumonia. Date ___/ ___/

Herpes Zoster. Date ___/ ___/
HPV. Date ___/ ___/

How would you usually rate your health?
Excellent ______ Average ______ Poor

Would you estimate that health problems keep you from your day’s work or activities:
Never ______ Occasionally ______
Sometimes ______ Often

If health problems keep you from your daily activities, what health problem bothers you the most? __________________

Would you say that your health in the past 6 weeks has:
Improved ________ Stayed the same ________ Declined ________

Date ________ Signed ______________________

Follow-Up
Review and follow-up of laboratory testing, telephone calls to patients who need follow-up contact, and telephone calls to other providers about patient issues are all tasks that providers or some staff member who is integrally involved in patient care must be responsible for. If a provider is
to do these things, there must be time built in to the schedule. If another staff member is to do these things, there must be systems for communication between the provider, helper, and patient, as well as documentation in medical records.

**Will the Practice Use an Electronic Health Record, and If So, Which One?**

Given the advantages of electronic health records and the trend in that direction, it makes sense for a brand new practice to begin with an electronic record. To answer the question of which record is best, start with articles in medical trade journals about the top electronic records, make inquiries, and then comparison shop. Ask other practice owners about the pros and cons of their systems. Or a practitioner could start with paper records and then transfer the information to an electronic record later. That is a major undertaking however.

**Where Will I Get Malpractice Insurance?**

There are several companies that offer professional liability insurance to NPs. Their policies and premiums change from time to time so the new practice owner will need to inquire about coverage, limits, and requirements 30–60 days before
opening. A practice owner will want a policy that covers not only the NP practice owner but also any other staff or clinicians working there. Among the questions to ask an insurer are:

- Is your policy occurrence or claims made? (Occurrence is preferable.)
- Will the policy cover me and my employees?
- Will the policy cover a physician, if physician collaboration is required in the state?
- What are the policy exclusions?
- What are the limits?
- May I read the policy before purchasing the insurance?
- Does the policy cover license defense or any other expenses in addition to damages for malpractice and legal expenses?
- What is the premium?

What Form Will the Business Take?
There are four options for the business structure of a practice: sole proprietorship, partnership, limited liability company (LLC), and corporation.

Sole Proprietorship
In a sole proprietorship, the business and the individual are one and the same. Any debts or legal liability are the responsibility of the individual owner.
The owner files tax information on a Schedule C, along with her or his tax return. Year-end losses can be deducted from the individual’s taxable income. Year-end profits are added to other income the individual may have and taxed accordingly.

Advantages of a sole proprietorship include the following:

- The owner makes all decisions.
- Losses can be deducted from personal/family income.
- There is no potential liability for purchases, mistakes, or bad judgment of a partner.
- There is no double taxation as is possible with a corporation.

There are disadvantages of a sole proprietorship as well:

- There is no one to help with expenses of start-up and maintenance.
- Ups and downs are dealt with alone.

**Partnership**
A partnership is a business relationship involving two or more individuals or business entities. Most partnerships spell out the relationships between or among the parties in a partnership agreement. If there is no partnership agreement, state law
governs the relationships. Partners are liable for the debts and legal liabilities of one another. Partners share profits, decision making, administration, and workload in some way that is agreeable to all.

Profits and losses in a partnership are divided and deducted or added to an individual’s tax forms. The partnership has a tax form, and the partnership’s distributions of profits or losses to the individuals involved appear on the individuals’ tax forms.

A lawsuit against a partnership implies liability for all partners. A debt incurred by one partner is a debt shared by all partners.

The major decisions to be made by partners are as follows:

- What happens if one partner wants out?
- Who inherits if one partner dies?
- How will profits and losses be divided?
- What contribution to start-up expenses will each partner make?
- How will duties be carried out?
- How will decisions be made?
- How will disputes be settled?

Advantages of a partnership include the following:
- Risk is shared.
- Success and failure are shared.
- Losses can be deducted from individual partners’ taxable income.
- There is backup for individual partners in the practice.

There are also disadvantages of a partnership:

- The debts incurred by one partner are the debts of the partnership.
- A partner may be liable for another partner’s mistakes.
- There are many opportunities for disputes between partners.
- A less productive partner will affect all other partners.

**Limited Liability Company**

A limited liability company (LLC) combines some of the best attributes of partnership with the best attributes of a corporation. State laws vary regarding the specifics of LLCs. The general provisions, however, are as follows:

- Income passes through to the individual members of an LLC, as in a partnership.
- Losses pass through to the individuals, as in a partnership.
- Individual members are liable for the debts of the company only up to a limit.
- Members agree on operational matters through a written document. If there is no written agreement, differences are settled according to state law regarding LLCs.
- Professionals may form LLCs.

The main advantage of an LLC is that this business form combines the best of partnerships and corporations. There are also disadvantages, however, including the following:

- A state may not include the LLC in its legal forms of business entities.
- The law is not as extensive in addressing this form as the other forms.
- States may have specific conditions that must be met before forming an LLC.

A professional forming an LLC is still liable for professional malpractice. However, in other forms of lawsuits against an LLC, the business entity affords protection against individual liability as in corporations.

**Corporation**

A corporation is a business entity with its own identity. Although one individual may be the sole
stockholder, director, and officer—the owner—the corporation is nevertheless a separate legal entity.

Under state law, professionals often must form a specific type of corporation with specific laws. Called a professional corporation or professional association, this form of company resembles a general corporation in many ways. The corporation has its own identifying number with the Internal Revenue Service (IRS) and files a tax return. Decisions are made by officers, a board of directors, and stockholders. In some states, stockholders must be like-licensed professionals.

Advantages of a corporation are as follows:

- When several individuals have ownership interest in the business, there are mechanisms for decision making and dispute resolution.
- There are set mechanisms for dividing profits and losses, based on capital contribution and professional work done.
- Many corporations like to deal with other corporations.
- The expenses of doing business are taken from a central pool before distribution of profits to stockholders.
There are legal limits on the personal liability of individuals.

There are disadvantages as well:

- A great deal of paperwork is required by state and federal governments.
- Corporate profits are taxed, and thus an owner could pay tax on corporate profits and pay again on a distribution of profits.

**Liability ramifications.**
A corporation is often liable for corporate debts, rather than each individual stockholder being liable. Professionals are not shielded from malpractice liability, however.

**Professional corporations.**
Some states’ laws prohibit the forming of a professional corporation by professionals with differing forms of licenses—for example, nurses and physicians. Before an NP attempts to form a corporation with a physician, he or she should consult state law.

**Choice of corporate structure.**
State laws governing partnerships, corporations, and LLCs differ. Consult a local attorney about choosing a business form and drafting the necessary legal documents.
Corporate practice of medicine doctrine. This doctrine is based on a tradition that medicine and business do not mix. Some states have ignored or dispensed with this doctrine. In other states, it is still on the legal books. Nevertheless, professional corporations are an option in every state.

What Systems Need to Be Set Up? In addition to systems for tracking quality and quantity of care provided, systems will be necessary for these items:

- Tracking inventory of supplies
- Purchasing supplies
- Purchasing equipment
- Getting equipment repaired
- Depositing cash at day’s end
- Disposing of hazardous waste
- Protecting patient confidentiality and privacy

There will be local vendors with whom accounts can be opened and arrangements made for each of these tasks.

Who Will the Practice Hire to Help? An early decision to be made is the necessary number of support staff. What kind of talents and
skills will be needed? Where can these employees be found?

New practice owners are likely to use past experience to judge how much employed help will be needed. Minimum services include these:

- Reception/appointment making
- Billing
- Cleaning
- Accounting
- Payroll
- Legal
- Medical assistance

In the near future, practices may need to hire a company (“registry”) to help compile quality measurement data. Many of these services can be obtained on an as-needed basis as opposed to hiring employees. In many communities, medical billing is done by billing services, as is payroll. Reception and appointment making, however, are almost always done by employees of the practice.

**Business Planning**

The success of a practice is closely related to several factors that can be researched prior to opening the business. Those factors include the following:
The need for the services in the community
Community interest in the services to be provided
The size of the potential patient pool in the community
The willingness of the community to use the services of an NP
The willingness of third-party payers to reimburse NPs for services

The best way to plan for a practice is to produce a business plan. A business plan is a written document that answers these questions:

- What do you plan to offer?
- How will you market the services?
- Who will purchase the services?
- Where will the business be located?
- How big will the practice be?
- How will the practice’s activities, policies, and procedures be organized?
- How will expenses be covered?
- What are the potential problems with the business?
- How will those problems be dealt with?
- What start-up money is needed, if any?
- What form will start-up funds take: equity or debt?
- How will start-up costs be repaid?
Often used to convince investors to invest or lenders to lend money to get the business started, a business plan is also an exercise that forces someone who is considering starting a business to research its feasibility and organize a plan for carrying out the business goals.

Writing a Business Plan for an NP Practice

A business plan can run 25 to 40 pages and cost thousands of dollars in consulting fees. A short version may be satisfactory if a business owner is looking for a rather small start-up loan and few investors are needed. Some NPs who have started practices have enlisted students in graduate business programs to create business plans for them as part of a class project. In these cases, the NPs have gotten a business plan for a much lower rate than is often commanded. For the do-it-yourself enthusiast, there are business plan software programs that an NP can adapt to suit his or her purposes.

At a minimum, a business plan for an NP practice should include these items:

- A list of services provided to patients
- Evidence of the need for those services
- Projections for the practice’s income compared with expenses
- A description of the principal movers who are starting the business, including their relevant experience and skills
- An organizational plan
- A plan for managing the day-to-day operations
- Investment needs
- Potential problems and critical risks

A sample business plan is given in Appendix 11-C.

**Services Provided**

In a business plan, an NP contemplating a practice venture lists the services to be offered. For example, in a primary care practice, the likely services might include the following:

- Health assessment (histories and physicals)
- Management and treatment of acute episodic illnesses and chronic stable illnesses
- Preventive education and counseling
- Screening for health maintenance
- Urgent care, such as stitching of lacerations and incision and drainage of certain lesions

**Evidence of the Need for Those Services**

If a proposed location for the practice is in a community that has been documented as underserved for the services just listed, the
business plan should cite the documents evidencing lack of primary care services. On the other hand, if the location is adequately served but the practice is offering some more attractive way of providing the service, the business plan should describe how the new practice will participate in the current market.

**Projections for the Practice’s Income Compared with Expenses**
This part of a business plan requires the writer to estimate. Some knowledge of the economics of private practice will be necessary to complete this section. In the case of an NP practice, one would need to know the number of people in the community who are potential patients, the income that could be expected per enrolled patient or per patient visit, the going rate of collected billings in similar practices, and the projected expenses of the practice. Expenses such as rent would be documented by citing classified ads for business space or by an oral quotation from a commercial realtor based on the number of square feet needed and the location.

**Description of the Principal Movers Who Are Starting the Business**
This section is résumé material. It answers the question “Do these potential business owners have
the relevant experience and skills to make a go of the business?"

**Organizational Plan**
If there is to be more than one owner/director, the principal movers should draw up an organizational chart that shows how authority will be distributed.

**Plan for Managing the Day-to-Day Operations**
Practice owners who are also providers may want to have a nonprovider—an office manager—handle the day-to-day operations.

**Investment Needs**
If outside funds are needed for start-up, the business plan should include an estimate of what is needed. If partners or corporate codirectors are contributing start-up funds, the business plan should state who is contributing and how much and state a plan for return on or repayment of investment.

**Potential Problems and Critical Risks**
If there are known risks to the business, the owners should state these risks in the business plan and state a plan for addressing those risks. For example, if an NP knows that local managed-care organizations (MCOs) are reluctant to admit NPs to
provider panels, thereby creating a potential inability to collect reimbursement, the NP should include this risk in the business plan and offer a strategy for addressing or minimizing it. An example would be meeting, prior to the opening of the practice, with MCO executives and obtaining a letter that one or more MCOs are willing to admit NPs as providers.

A Business Plan’s Top 20 Questions

Usually a business plan answers 20 questions, the questions that most people will ask about the business. The 20 questions that are most asked of owners of new businesses and that an NP thinking of opening a practice should be prepared to answer are these:

1. What type of business do you have?
2. What is the purpose of this business?
3. What is the key message or one-sentence phrase that can describe your business?
4. What is your reason for starting your own business?
5. What is your product or service?
6. What are three unique benefits of your product?
7. Do you have data sheets, brochures, diagrams, sketches, photographs, related
press releases, or other documentation about your product/service?

8. What is the product?

9. What led you to develop your product?

10. Is this product or service used in connection with other products?

11. What are the top three objections to buying your product/service immediately?

12. When will your product be available?

13. Who is your target audience?

14. Who is your competition?

15. How is your product differentiated from that of your competition?

16. What is the pricing of your product versus that of your competition?

17. Are you making any special offers?

18. What plans do you have for advertising and promotions?

19. How will you finance company growth?

20. Do you have the management team needed to achieve your goals?

Sections of a Business Plan

The following are the customary sections of a business plan:

- Executive summary
- Vision/mission statement
A typical way to begin is to answer the top 20 questions. From the answers, it is possible to develop the executive summary and then to work on the details of the sections one at a time.

An NP entrepreneur (or any entrepreneur) is not expected to be an expert on writing a business plan. An entrepreneur should be prepared to answer these 20 questions, however, so that a business
A consultant will have some substance to use as the framework for developing the plan.

It is common for someone with an idea for a business to give it up after considering all of the questions brought up by a business plan. If this happens, the exercise of producing a business plan will have saved substantial time and money.

**Getting a Business Loan**

A prospective practice owner may want a bank loan or a venture capitalist’s investment to cover the expenses of start-up. A business plan will set out the start-up costs and a plan for repayment.

**Multiple Uses of a Business Plan**

In addition to helping a potential future practice owner decide whether a practice will be profitable and helping lenders decide whether to participate, a business plan can be used to orient employees, suppliers, and other people with whom the business will deal. A strong business plan points out to the practice owner potential adversities and weak areas, giving an opportunity to respond before there is a business failure.

**Resources for Getting Help with a Business Plan**
Among the resources for more information on business plans are the Small Business Administration and the Service Corps of Retired Executives, both of which are listed in the telephone book and can also be found through an online search. Other possible resources are business consultants, business-oriented community groups, professional organizations and journals, business consultants, web articles, and public libraries. Every local library should have at least one book on writing a business plan.

**Looking at the Big Picture**
An NP planning to start a practice will need to take a look at the healthcare industry in general, and particularly the climate in the NP’s geographic area. Whether there is a need for the NP in practice to fill, whether there will be enough business to support the practice, and whether there are any barriers to overcome are three issues that an assessment of “the big picture” can address. The big picture includes the business climate, the competition, the law regarding NPs, and patient and public perceptions of NPs. All of these considerations will affect how the practice does and whether it will survive. An investor or lender reviewing a business plan will be impressed by a plan that takes the big picture into account.
Looking at the Smaller Picture

An NP considering starting a practice also will need to consider how entrepreneurship and business ownership will affect her or his life. Possible effects of small business ownership on an individual include the following:

- Lack of a separation between work life and personal life
- Necessity of an investment of time and money in start-up
- Inconsistent income while the practice is growing
- Uncertainty about success of the business
- Anxiety about the ability of partners or coworkers to hold up their end

Doing Business

Several responsibilities come with being a practice owner:

- Protecting the confidentiality of and storage of patient records
- Carrying out the responsibilities of an employer (discussed shortly in more detail)
- Registering the practice name with local government
- Disposing of hazardous waste produced in the course of business
Complying with fire marshal inspections and building codes
- Maintaining the laboratory facilities in accordance with federal and state law
- Credentialing providers
- Ensuring that hiring and firing are done in accordance with the nondiscrimination provisions of law
- Providing malpractice coverage for the providers or company
- Providing general liability for the practice (against slip and fall or other injuries to patients)
- Providing after-hours contact information and coverage

Responsibilities of an Employer
Employers have legal and practical responsibilities. Legal responsibilities include the following:

- Withholding and paying employment taxes
- Ascertaining that a hiree is an American citizen or legal immigrant
- Paying workers’ compensation and unemployment insurance premiums for employees
- Ensuring that employees actually have the credentials and licenses that they say they have
- Conducting background checks before hiring to decrease the risk that an employee might cause
harm to a patient or have been barred from Medicare or Medicaid, or will otherwise adversely affect the quality of or finances of the practice

- Training employees to provide safe care or ensuring that hired employees are already adequately trained
- Ensuring that employees have a safe working environment
- Complying with the provisions of the Americans with Disabilities Act, which prohibits discrimination against a prospective hiree with a disability who needs only “reasonable accommodation” to do the proposed job

Practically, employers want to hire employees who have social skills, are motivated to perform, and will either make decisions or take direction, depending on the need.

**Employment Agreements**

In most states, employment is “at will.” In an at will state, an employer may end an employee’s job at any time. Likewise, an employee may leave a job at any time. Good public relations dictates reasonable notice, but there is no legal requirement for notice. Except for a few protections provided by federal law—protection against firing on the basis of race, age, gender, or exercise of free speech—employees are
employees at the will of the employer. Therefore, an employer who wants to ensure that an employee will stay with the practice for a specified length of time will want to have employment agreements with employees. Employees will find employment agreements useful as well.¹

**Employee Rights**

The rights of an employee include coverage by workers’ compensation and unemployment insurance, a safe working environment to the extent specified by the Occupational Safety and Health Act, and freedom from discrimination on the basis of race, gender, national origin, religion, age, or disability. An employee has a right to health insurance according to some state laws, under certain conditions. A new employer should check the laws of the state regarding employer responsibilities.

**Employer Rights**

An employer has no legal rights unless rights are specified in a contract.

**Independent Contractors**

A practice owner may want to hire some staff as independent contractors. An independent contractor is not an employee. An employer’s responsibilities
to independent contractors are only those specified by a contract between the practice owner and independent contractor. An independent contractor is responsible for his or her own taxes, insurance, health benefits, tools, and possibly supplies and workspace.

An employer must withhold payroll taxes—income, Medicare, Social Security, and unemployment—for employees. An employer is responsible for paying workers’ compensation to an employee injured on the job. In some states, small businesses must offer health benefits to employees. An employer may be held responsible for the malpractice of an employee and therefore should have professional liability insurance covering employees. All of these employer responsibilities are expensive to maintain.

An employer cannot avoid the legal responsibilities connected with being an employer by calling an employee an independent contractor, however. The IRS and other governmental agencies may investigate an employer who appears to be avoiding insurance and taxes by claiming that workers are independent contractors. To minimize unpleasant contact with the IRS, an employer should know the important, but subtle, legal distinctions between employees and independent contractors.
Employee Versus Independent Contractor

In determining whether an individual is an employee or independent contractor, the following matters are considered:

- The extent of control that, by agreement, the employer may exercise over the details of the work
- Whether the one employed is engaged in a distinct occupation or business
- The kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision
- The skill required in a particular occupation
- Whether the employer or the worker supplies the instruments, tools, and place of work for the person doing the work
- The length of time for which the person is employed
- The method of payment, whether by the time spent or by the job
- Whether the work is a part of the regular business of the employer
- Whether the parties believe they are creating the relationship of employer and employee
- Whether the principal is or is not in business

What Is an Employee?
Consider this example case: NP Jones, after working for Physician Smith for 5 years, noticed that a nearby town, growing in size, was lacking a healthcare provider. NP Jones, familiar with the current sources of reimbursement for NPs, drew up a business plan and determined that he could, in fact, support himself if he left the employ of the physician and set up a private practice.

NP Jones asked Dr. Smith to supply, for a fee, medical backup for his practice and to collaborate via a written agreement. Dr. Smith agreed to provide those things and offered to cover one session a week at the new practice for a percentage of the reimbursed charges.

Is Dr. Smith now an employee of NP Jones? Can NP Jones avoid the responsibilities of being an employer? Under the circumstances described here, Dr. Smith is considered an employee of NP Jones.

These are the factors that make Dr. Smith an employee:

- NP Jones will control when the job is done and the place where it is done.
- NP Jones will hire the medical assistant with whom Dr. Smith will work.
NP Jones will supply the equipment necessary to do the job.

NP Jones, not Dr. Smith, will suffer financial losses if the work does not produce income for the practice.

Clearly, an independent contractor would be less expensive. A physician who provided consultation as needed, at an hourly rate, over the telephone, would be an independent contractor. To ensure that the IRS will view the physician as such, the NP should have the physician do the following:

- Bill the NP periodically on the physician’s stationery for work done
- Bill the NP varying amounts, corresponding with the work performed (a standard weekly or monthly fee sounds like a salary)
- Not work at the NP’s place of business

In addition, the NP and physician should draft and sign an independent contractor agreement, spelling out, at minimum, the duties and responsibilities of both parties, the duration of the agreement, and the rate and method of payment. See Appendix 11-D for a sample contract between an NP and a physician for consultation services.

Note that a contract alone will not transform an employment situation into an independent
contractor arrangement. Some business owners have attempted to make employees independent contractors by writing a contract stating that the arrangement is one of independent contractors, not employer–employee. The IRS is unimpressed with this maneuver. The IRS, if it determines that the NP was an employer and did not provide proper coverage for employees, could fine the NP and create other business headaches. Furthermore, returning to the previous example given, if Dr. Smith suffers a needlestick at NP Jones’s place of business, Dr. Smith will want workers’ compensation. The Workers’ Compensation Commission is likely to find that Dr. Smith was an employee, and NP Jones will be liable for compensating Dr. Smith for his injuries and lost wages.

**Employment Contracts and Independent Contractor Contracts**

Prospective practice owners should consult attorneys when drafting employment or independent contractor agreements. They are different contracts. A contract for an independent contractor should not only state that the relationship is one of independent contractor but also show how the relationship fits the definition of independent contractor. An employer who attempts to avoid employer
responsibilities by calling an arrangement an independent contractor arrangement when it actually fits the definition of employment will need an attorney for representation before the IRS.

**Evaluating Performance**
An employer will want to evaluate the performance of all employees on a regular basis. Employees who are adding value to a practice should be rewarded, and employees who are not worth the money paid to them should be encouraged to improve performance or leave. To approach performance evaluation rationally, a set of expectations should be drafted and agreed upon by both employer and employee. In some organizations, a new employee has an evaluation at 90 and 180 days and then yearly. In other organizations, a yearly performance review is the standard.

**Terminating Personnel Legally**
An employer who wants to terminate a staff member should consider legal necessities and public relations realities. Legally, an employer may not terminate an employee solely on the basis of race, age, gender, religion, national origin, or disability. That is not to say that an employer may never terminate a minority or older employee. The law simply requires that termination not be solely on that
basis. Independent contractors, on the other hand, can be terminated for any reason, pursuant to the conditions of a contract between contractor and contractee.

**Getting Paid for Services**
Practices have three general sources of income: patients who self-pay for services, insurance, and contracts.

**Self-Paying Patients**
Generally, patients who pay their own bills are in the minority. However, patients who either are uninsured or prefer to go to a provider who is out of their plan but attractive for reasons of convenience or service appreciate a provider who can offer medical services at a reasonable rate. An NP may want to market to such patients.

For convenience to both the patient and the practice owner, a practice may want to set up a charge account with a major credit card company. A practice owner also must decide whether to extend credit to patients and, if so, how to deal with delinquent payments.

**Insurers**
Insurers fall into two categories: MCOs and indemnity insurers. MCOs contract with an employer to provide, for a set sum, all health services, with some exceptions, needed by employees for a year. MCOs contract with practices or groups to provide health services on a capitated or fee-for-service basis. Fee-for-service is the predominant payment system. A practice must be admitted to panels of MCO providers and have a contract that contains the details of the arrangement between the provider and the MCO. Indemnity insurers likewise contract with employers to provide health services, with exceptions, for employees. Indemnity insurers pay providers’ bills, according to a fee schedule, on a fee-for-service basis. Indemnity insurers have no relationship with providers other than to pay bills presented by the provider to the insurer for the care of a covered patient.

Obtaining payments from third-party payers is not necessarily any easier than obtaining payment from patients directly. It can be 3 months between the time the provider bills the insurer and when the provider receives the insurer’s payment. When payment is capitated, practices sometimes have trouble establishing that a patient was, in fact, enrolled with the individual provider and with the MCO at the time the care was given.
Contracts
Practices may contract with businesses to provide certain health services, under any sort of arrangement that is agreed upon by both parties.

Applying for Provider Status
It is important for NPs opening a practice to gain admission to some managed-care provider panels for the following reasons:

- If NPs do not appear in MCO directories of providers, and if an NP’s name is not on the patients’ cards as the primary care provider (PCP), patients are going to think that the NP is some sort of assistant provider. They will not take the NP’s advice as seriously as they would take advice from a “real provider.”
- It is necessary to get paid.

There are other sources of direct reimbursement: Medicare, Medicaid, indemnity insurers, and direct payments from patients or companies. However, many patients covered by Medicare and Medicaid and more and more patients previously covered by indemnity insurers are now enrolling in MCOs.

If NPs do not become providers for those MCOs, they will not have access to a large portion of the patient population. The goal of NPs realistically
should be to see patients as full-fledged providers, not under the auspices of physicians. The relationship should be one of consultation, not supervision.

Attaining the designation of PCP or “medical home” from MCOs, with all of its attendant authority and responsibilities, is now one of the most important professional goals for NPs. Some NPs have attained the goal. Others are still trying, and in the meantime they are working on NP–MD teams where an MD is the designated PCP. Some NPs do not want the responsibilities attached to being a PCP or medical home and are content to assist a physician or other NP.

The argument that NPs should be admitted to MCO panels as PCPs can be tailored to the target of the persuasion. Next are some of the arguments supporting NP admission to provider panels as PCPs. There are specific arguments to make to physicians, MCOs, practice managers, and other NPs.

**Arguments to Physicians**
The following points may be helpful to raise with physicians:
If an NP works under a written agreement with a physician, but only the physician may be a PCP, then the physician will have to sign all of the referral forms for the NP’s patients. It is unwise for a physician to sign a referral unless he or she has reviewed the patient’s chart. Chart review for every referral written by an NP will require a significant time investment. On the other hand, if the NP is a PCP, then the NP can make referrals without investment of physician time.

If an NP with whom a physician is associated is a heavy referrer, and if all of the NP’s referrals are attributed to the physician (because the physician is the PCP), that will reflect poorly on the physician’s utilization rates with an MCO. An NP should be responsible for the NP’s referrals and a physician for the physician’s referrals.

If an NP does not make a necessary referral for a patient or misdiagnoses a problem, a physician who is the PCP for the patient involved bears ultimate responsibility and is much more likely to be liable in any future malpractice case than if the NP were the PCP. If the NP is the PCP, then it is far less likely that a physician will be found liable for any errors made by the NP.

**Arguments to MCOs**

Perhaps the toughest audience is the MCOs, whose executives may have little experience with NPs and
be used to dealing with physicians. When attempting to convince MCOs of the need to admit NPs to provider panels, consider using the following arguments:

- NPs fill MCOs’ needs of getting the job of patient care done in a high-quality and cost-effective manner. NPs are the appropriate providers of first-level care—that is, primary care. They are educated specifically for this role, enjoy this role, and are well accepted by patients. The top 10 reasons for visits to the doctor are hypertension, diabetes, acute upper respiratory infection, bronchitis, chronic sinusitis, acute pharyngitis, routine medical exam, inner ear infection, depressive disorder, and urinary tract infection. All of these illnesses are appropriate for NP management. It makes no sense to use a physician when an NP is perfectly suited for this role.
- In virtually every study done on the matter, NPs have been found to be high-quality providers, at least as safe and effective as physicians.
- In virtually every study done on the matter, NPs have been found to be cost-effective—more cost-effective than physicians.
- Patients are highly satisfied with NPs.
- NPs focus on the kind of care that the agencies that accredit MCOs are looking for. For example, NCQA has a set of standards for measuring clinical performance in primary care: HEDIS. HEDIS measures include:\(^2\)
  - Keeping childhood and adolescent immunizations current
  - Advising smokers to quit
  - Giving annual flu shots to older patients
  - Screening appropriately for cervical cancer
  - Screening appropriately for breast cancer
  - Checking on postpartum women within 6 weeks of delivery
  - Maintaining patients who have had myocardial infarctions with beta blockers
- Use physicians where necessary. Have NPs take care of patients where it makes sense to use NPs.

Certain arguments can backfire, for example, the argument that NPs can provide care for a lower fee than physicians. NPs in private practice do not want to undercut physician charges because they have to pay physicians to be their collaborators, as is required by the law of most states and by Medicare. If the NP is earning less than a PCP earns to care for a patient, where is the NP going to find the money to pay the physician collaborator?
Another thorny argument is that NPs have less malpractice litigation than physicians. It is true that claims against NPs are minuscule compared to claims against physicians. However, to be fair, there are many reasons for that. Yes, NPs have good relationships with their patients and are very conscientious, but NPs are not perceived by the public to be wealthy. Further, the reporting requirements are somewhat different for NPs, so the data may be misleading.

**Arguments to Practice Managers**
The following points may be persuasive with practice managers:

- It is unreasonable for an NP to stop in the middle of clinical sessions and interrupt a physician to present a case, when it is otherwise unnecessary, in order to get a signature for a referral. Some system must be set up to deal with referrals. If only physicians can be PCPs, it will ultimately fall on the practice manager to make sure that when there are physician–NP teams, the physicians are notified of what the NP is doing about referrals.
- Physicians cannot have panels of unlimited size. At some point, to keep patients within a practice, there will have to be NP PCPs.
Arguments to Other NPs

Being deemed a PCP by an MCO may seem like a semantic issue rather than a substantive issue. Granted, the issue is more professional than clinical. An NP can provide primary care whether or not she or he is formally designated a PCP. For example, patient Smith may see NP Jones several times a year and may consider NP Jones to be her healthcare provider, whether or not an MCO has designated NP Jones as patient Smith’s PCP. However, if NP Jones does not hold PCP status with patient Smith’s MCO, the NP is invisible to the MCO. To the MCO, patient Smith’s PCP is NP Jones’s employer, Dr. Doe. In some clinics, the patients have physicians whom they have never met named on their file as PCP. The clinic simply assigns some physician, any physician, to a patient who actually is cared for by an NP. Even though NP Jones evaluates patient Smith, orders diagnostic tests, makes referrals, and follows up, to the MCO, this is all done by Dr. Doe.

This arrangement works well for patient Smith. As long as NP Jones does a good job, the MCO, patient, physician PCP, and clinic will all be happy with the arrangement. But to the “invisible provider,” NP Jones, the arrangement means three things:
1. NP Jones is a ghost provider. Her work is seen only through Dr. Doe’s statistics and is indistinguishable from Dr. Doe’s. The NP is a “helper.”
2. Without data on NP Jones’s work, the situation will never change. An MCO will never know how many patients NP Jones sees; never know the effectiveness of her diagnosis, treatment, preventive efforts, and teaching; and never know that NP Jones draws patients to the practice.
3. NP Jones always will be working for Dr. Doe or another physician. NP Jones cannot ever have her own practice, because she can never prove that she is an effective healthcare provider. NP Jones is forever tied to Dr. Doe.

The dynamics of human nature will begin to work as soon as Dr. Doe understands that NP Jones is forever tied to a physician, unable to care for MCO patients as a PCP. Dr. Doe will not give NP Jones as high a level of professional respect as if NP Jones were an equal PCP, able to take her patients and start her own practice down the block. A deficit in professional respect may reveal itself on a daily basis or only at contract negotiation time. At some point, however, it is sure to manifest.
The selfless NP who wants only to take good care of patients and has no interest in challenging the physician’s role as captain of the healthcare ship should realize that the implications here reach far beyond issues of pecking order. Patients will see their MCO’s directory of providers and notice that NP Jones’s name is not listed. Patients will notice that a physician’s name, not NP Jones’s name, appears on their referral forms and their medical cards. Patients eventually will become aware that NP Jones is a “helper” rather than the PCP. The subtle message to patients is that NPs are not worthy of being relied on for advice about serious matters and not deserving of full attention when healthcare teaching is under way. The message may be completely erroneous, especially when an NP really is the patient’s primary decision maker, diagnostician, teacher, gatekeeper, confidant, and adviser—in effect, the PCP.

**How to Apply for Panel Admission**
First, answer the following questions:

- Is the law in place?
- Does state law permit an NP to be a managed-care provider?
- Is the practice ready for scrutiny?
- Will the practice physically present well during a site visit? Are health maintenance efforts well documented? Are records orderly?
- Are policies written, recently reviewed, and organized?
- Are the required relationships in place with a physician?
- If a written collaborative agreement is required by law, is it signed and approved by the appropriate board?
- Are the arguments ready? (See the arguments previously detailed.)

Give MCOs general information on NPs, such as educational requirements, malpractice actuarials, information on insurers that reimburse for NP services (e.g., Medicare, Medicaid, and Blue Cross), and scope of practice. Include articles on studies that demonstrate the cost-effectiveness and quality of NP practice. Also, give MCOs information on the specific practice, including credentials of each provider and description of the practice—location and size.

**What to Do If Rejected**

If rejected, rework the arguments or address the counterarguments, wait 6 months, and try again. The climate may have changed, or the presentation may be better the second time.
Effective Negotiation of Managed-Care Contracts

Once an MCO agrees to admit an NP, it will offer a contract. This section provides basics on negotiating such contracts. The following basics about managed-care contracting should be understood:

- Under capitated-care contracts, everything the provider does is paid for in one lump sum, with exceptions.
- “Everything” means everything that is included in the contract and everything that is not excluded or excepted by the contract.
- Many MCOs pay providers on a fee-for-service basis.
- Some MCOs pay providers through a combination of fee-for-service and capitated fees.

Preparing to Negotiate

A practice owner should ask other providers, and possibly the state insurance commissioner’s office, the following questions about an MCO with whom a practice is considering a contract:

- Have other providers been paid promptly?
- Are there specialists in the MCO’s referral network with whom the provider is familiar?
- Does the MCO have a strong presence in the community?
- Is the MCO financially sound?
- Is there a history of complaints about the company with the Insurance Division?
- Does the company have decent quality data?

**Use of Actuarial Data**
Actuaries make predictions about risks, usually insurance risks. An actuary can predict such practice variables as how many visits patients will make per year and what the average payment per visit will be. If possible, an NP seeking a contract with an MCO should obtain actuarial data on the group of patients whom the contract would cover. Sometimes MCOs can provide actuarial data on their patients. If not, an NP could hire an actuary. If an actuary is unaffordable and the MCO cannot supply actuarial data, an NP who has data from his or her own practice and/or access to charts can make some actuarial predictions on how many patient visits to expect per year and what the average payment per patient visit has been.

- Research the costs of the practice.
  1. Add up all salaries, rent, material costs, insurance costs, legal costs, and cleaning costs, that is, all the costs of doing business. See *Exhibit 11-1*. 
2. Divide by the number of patients for which a practice can reasonably expect to get a year’s capitation. The result will be the average yearly cap rate, per patient, needed to support the practice.

- Research the demographics of the practice.
  1. Age and gender will make a difference in the cap rate.
  2. Age and gender will make a difference in the time spent per patient.

- Decide on the product line to be offered. Will the practice offer primary care service to all age groups? Will the practice offer full well-woman care? EKGs on site? Suturing? Sigmoidoscopies? Incision and drainage? Asthmatic nebulization? A practice that offers a wider range of services can expect to refer fewer patients to other providers and can argue for a large capitation rate when a capitation form of payment is being negotiated.

- Research the capitation and fee-for-service rates for that payer. Ask insurers for their capitation rates and fee-for-service schedules early on. If data on capitation rates offered to other practices nearby are obtainable, obtain that information.
Negotiating
Here are some tips on negotiating a managed-care contract. They were suggested by physicians who signed whatever came their way in the first round and later learned from their mistakes.

- Think of the unsigned contract as the presenter’s opening offer. It is a biased offer. Understand that it is only a starting point in negotiations.
- Do not assume that any provision is nonnegotiable. It was written on a word processor and can be easily changed. Make counteroffers to strike unfavorable provisions and insert others that are favorable. Much will depend on how much the MCO wants the practice.
- Read the whole contract carefully—even the fine print. Make a photocopy and write notes and questions on it. Have an attorney answer any questions in plain English. If the contract refers to manuals or rules and regulations, review these before signing.
- Make certain the contract covers all important business. If something is not covered in the contract, the provision does not exist. Make sure oral promises are included in the written document.
1. Ask: Is there a way out for the provider if the dealings with the MCO turn out to be unbearable?

2. Watch the billing and payment provisions, details of quality and utilization reviews, restrictions on coverage arrangements, and limitations on referral and admission. Get it in writing that the MCO will pay clean claims within 30 days. Include a provision for regular utilization reports. Determine how the beginning and end of coverage for a client affects a provider’s duty to give care. Determine the limitations on and procedures for referral and admission. Determine what the MCO expects as far as quality data collection and performance on quality measures.

- Pay attention to the definitions at the beginning of the document, as definitions sometimes include substantive information, such as what is meant by “medically necessary services.”
- Hold-harmless clauses usually work against an NP provider. They can be applied to a variety of situations. For example, a contract might state that “provider holds enrollee harmless for charges,” even if the MCO becomes insolvent and does not pay the provider. Or it might state
that “the provider holds MCO harmless in regard to any lawsuit filed by a patient against provider.” Do not agree to such a clause unless the practice’s liability insurance carrier signs off on it.

- Indemnification clauses: Indemnification means make whole or compensate for some loss or damage. Do not agree to indemnify the MCO for any loss by the MCO.

- No-cause termination: Try to avoid a situation where an MCO could terminate the relationship at any time, without good cause. Instead, insert a due-process clause, which allows a hearing in front of peers to determine whether termination has good cause.

- Do not negotiate jointly with anyone other than practice partners or other members of an integrated network. Practices differ greatly and need practice-specific contracts.

- Once the parties sign, the contract is binding.

In addition, here are four self-assessment questions to ask:

1. Can I live with this MCO’s rates?
2. Can I live with the other requirements?
3. Can I negotiate with the MCO on any of the issues important to me?
4. Can I alter the system of care from the traditional model to a more efficient and
Enlist the help of an experienced attorney in negotiating the terms of the contract. The practice’s accountant should review the payment mechanisms. The practice’s business manager should evaluate the mechanics of payment, the timing of reimbursement, and the requirements for approvals of referrals.

Notes

Appendix 11-A: A Checklist for Setting Up a Practice

NPs who are contemplating going into private practice have few role-model colleagues to consult with, and those NPs who do run their own practices have little free time to consult with fledgling entrepreneurs.

This checklist fills in gaps in knowledge, giving NPs a description of things to do, think about, and decide on before setting up a practice. Some of the things to do will vary from state to state, and some are common to NPs in all states.

Administration

A practice may have one owner or many. The three basic business forms are sole practitioner, partnership, and corporation. Each of these forms suggests an administrative structure. If an NP is starting a business alone, there will be no confusion about who makes administrative decisions. Whenever more than one person is involved, however, there is the question of who should make
the many decisions necessary to run a practice and how the decision making will be done. Draw up an administrative chart as one of the first tasks in the planning process.

**Billing**
Many practices have a billing clerk. Others hire outside companies to do the billing. An outside billing company may take a percentage of the income or charge a fee per bill.

**Private Insurers**
Each insurance company has a procedure for enlisting providers. Develop a list of insurers’ names, addresses, and telephone numbers. Call each company’s provider relations office and ask the following questions:

- What is the policy of the company regarding reimbursement for NP services?
- What is the process for reimbursement?
- How does an NP apply for a provider number?

Ask for an application to become a provider, fill out and return the application, and deal with the responses one by one.

If a rejection comes in the mail, follow up with telephone calls or letters to find out why. Some
states have laws that require third-party payers to reimburse NPs for services performed. If there is such a law in your state, include a copy of it with your correspondence.

**Business Associates**
Under the Health Insurance Portability and Accountability Act (HIPAA), the business associates of healthcare providers are required by contract to protect the privacy of patient information if a business associate has access to this information. Therefore, a practice must have an agreement with business associates to this effect.

**Business Form**
A sole proprietor is solely responsible for the business. Legal liability and liability for taxes lie with the sole proprietor. In a partnership, each partner shares the profits and liabilities. Each partner pays taxes on her or his own earnings. Each partner has personal liability for debts and judgments against the business.

There are several forms of corporations. A corporation is an entity apart from the individuals involved in the business. A corporation pays taxes on profits, the employees pay taxes on their income, and the shareholders pay taxes on their dividends.
The corporation is liable for debts and judgments against the company. However, if corporate assets are insufficient to cover debts or other liabilities, corporate officers or directors may be personally liable. A corporation that provides medical services usually is required by state law to be a particular form of corporation: a professional corporation (PC) or professional association (PA).

A limited liability company (LLC) combines some aspects of the corporation and some aspects of partnership. In some states, an LLC may have the corporate purpose of delivering medical care. An LLC should be considered when there is more than one provider and the providers are considering partnership.

Consult an attorney when choosing a business form.

**Call**
Set up a system for ensuring that patients have 24-hour access to providers.

**Chaperones**
The need for a chaperone during a patient visit is based on the nature of the visit and the gender of the provider and the patient. The provider often will
not know the nature of the visit until the patient is in the room.

Consider the following patient–provider combinations:

- Male provider, female patient
- Same-sex provider and patient
- Female provider, male patient
- Unaccompanied minor patient of either sex with provider of either sex

The need for chaperones should be kept in mind when considering staffing.

Calling in chaperones for all patient visits may inhibit the back and forth between the NP and patient. On the other hand, practitioners who forget to call in a chaperone may later find themselves accused of improper behavior by a patient and that they have no witnesses to refute these accusations. The most reasonable policy regarding chaperones is to offer the patient the option of having one.

**Compliance**

If the practice will bill third-party payers, the practice should have a compliance plan in which the practice describes how it will oversee itself as far as billing according to payer rules. For more information on

**Computer System**

Answer the following questions:

- What software will be used for billing? For medical records? For tracking quality data?
- Is the software compatible with Medicare and Medicaid systems?
- Does it meet the federal standards for e-prescribing?
- How many terminals are needed?
- Will providers enter medical record data, and if so, will entry be done in the exam room with the patient present or later?
- What sort of networking is needed?
- Will Internet service be needed? Email?
- What are the provisions for patient confidentiality of data kept on a computer?

Point-of-care medical data entry requires that practitioners be well versed in the data entry system or that a transcriptionist or scribe be hired.

**Confidentiality**
Each practice should have a HIPAA compliance plan. Sample plans are available online.

Answer these questions:

- How will patient confidentiality be maintained?
- Will patients have privacy when announcing the reason for their visit at the receptionist’s desk?
- Will discarded notes and lab results be shredded?
- Is there an area where the provider and assistants can talk about plans for patients without other patients hearing the discussion?
- Are exam and conference rooms reasonably soundproof?
- Are rooms laid out such that a patient in a gown cannot be seen by waiting patients?

Concerning release of medical record information:
Any provider, clinic, or hospital needs written permission from a patient to give out medical information about that patient for any reason other than treatment, payment, or healthcare operations. When a patient’s medical problem is substance abuse, federal law requires that certain language be used in the consent for release of information.

All employees should be aware of the need to protect patient confidentiality when responding to
telephone inquiries from or about patients and the need for keeping progress notes, incoming lab tests, and mail about patients private.

**Copy Machines, Fax**
Some practice management consultants recommend that providers each have fax and copying machines within arm’s reach. Every practice needs at least one of each. (Smartphones and computers may eventually replace fax and copying machines but the new technologies require attention to compliance with federal and state privacy regulations.)

**Credentialing**
For each NP, the clinic manager should have the following items:

- A copy of the NP’s current state license as an advanced practice nurse (and check the state board of nursing website for any encumbrances on the NP’s license)
- A copy of the NP’s current certification by a certifying organization
- A copy of two professional references, including name, address, telephone number, title, nature of professional association with employee, and recommendation regarding the employee’s
clinical competence and ability to work with a team

- A statement signed by the NP declaring that the NP has never been convicted of a felony, is not under investigation for suspected commission of a felony, is not under investigation by the board of nursing for a licensing offense, and has not been suspended from Medicaid or Medicare provider status

- A statement of the NP’s malpractice history. The National Practitioner Data Bank (NPDB) keeps records of all damage awards for medical malpractice paid by a practitioner (MD, DDS, or NP). A practitioner can get his or her own report by requesting a form from the NPDB. Hospitals can subscribe to the service.

- The practice agreement under which the NP is practicing. In many states, each NP must have a written practice agreement with a physician specifying what the NP may do, what kind of oversight the physician will give, and the site of practice. The agreement must be signed by each party and approved by the board of nursing.

- Prescribing authority. Providers need to obtain Drug Enforcement Administration (DEA) numbers and may need state controlled dangerous substance (CDS) numbers. Contact
the state health department and the DEA for an application.

- A copy of the NP’s current cardiopulmonary resuscitation card
- The NP’s National Provider Identifier

**Disability Patients with Disabilities**
Each place of business should be wheelchair accessible in order to avoid unlawful discrimination against the patients with disabilities.

**Screening Patients for Medicaid Eligibility**
Clients may receive Medicaid because they are low income with children or because they, as adults, have disabilities. NPs may be asked to do disability evaluations. In the disability determination process, the client obtains a form from his or her local Department of Social Services (DSS) office, fills out the required information, and brings it to the clinic. The NP does a history and physical exam to determine whether the client has a disability and is unable to work and how long the client will be disabled. The client’s eligibility for services depends on the projected length of disability. A clinic may obtain the financial criteria that qualify a family for welfare from the local DSS and make referrals to the DSS accordingly.
Screening Patients for Medicare Disability
As of the publication date of this text, NPs do not have the legal authority to determine disability under the Medicare program.

Employee Disability
Employees of the practice who injure themselves on the job will seek workers’ compensation. Practices should carry insurance to cover such claims.

Doctors, Medical
If a state requires physician collaboration, an NP may hire or contract with a physician to provide consultation services and develop and sign a written agreement as required by law. A physician’s fee might be an annual or monthly retainer payment, a percentage of collections, a rate per hour of consultation time, or another arrangement that is agreeable to the parties. An NP may want to establish a partnership with a physician, contract with a physician for specific consulting services, or hire a physician as an employee. For an example of a contract between an NP and a physician for physician consultation services, see Appendix 11-D.
When an NP hires or contracts with a physician, the parties agree that the profits, as well as the liabilities, are the NP’s. In a partnership, profits and liabilities are shared among the partners.

The owners of a new practice may find it most economical to engage a physician as an independent contractor rather than hire the physician as an employee. When taking on a physician consultant, specify in the contract that the physician is an independent contractor, specify an hourly rate of payment and terms of payment, and specify the duties and responsibilities of the physician and of the NP. In addition to a practice agreement that fulfills the requirements of state law, the NP and physician should have an employment or professional services agreement. The former is the professional collaboration agreement; the latter is the business arrangement between the two individuals.

**Emergency Plan**

Establish a written emergency plan that answers these questions:

- How much emergency care will the NP give?
- What are the criteria for referral to the nearest emergency department?
- For calling 911?
- For ambulance transport?

Each practice also needs a plan for emergencies, such as:

- Patient loss of consciousness or other life-threatening emergency
- Fire on the premises
- Threats to safety from intruders or unruly patients
- Uncontained hazardous wastes

**Employees**

Anyone who hires another person legally must determine that the employee is an American citizen or a legal alien and that the employee is certified or licensed as necessary. An employer may be held liable for any injuries that an employee causes to a patient.

Employers should consider checking state registries of sexual offenders before hiring an individual.

Employers are responsible for keeping records of employees’ Social Security wages, Medicare wages, and income tax wages. Most employers pay at least a portion of employees’ Social Security. All employers are required to withhold income tax from employee wages. In some states, employers must
register their employees in a state registry for the purpose of tracking individuals who owe child support.

Employers should carry workers’ compensation insurance, payroll insurance, and health insurance for employees in accordance with state laws.

**Forms**
Forms should be developed for these items:

- Intake (name, address, telephone, insurance company and numbers, birth date, etc.)
- History and physical
- Tracking of healthcare maintenance and screening
- Care plan/problem list
- Progress note
- Referral
- Return to work
- Appointment slips
- Appointments (calendar)
- Encounter/billing
- Release of medical information
- General consent to treatment
- Consent to procedure
- Patient instructions
- Lab report flow sheet
Vital sign flow sheet
Patient contact
Notice of patient privacy rights

Guardians
Any patient who has a legal guardian may not sign consent forms (or give consent) for care.

Health Maintenance Organizations
Many health maintenance organizations (HMOs) are contracting with NP practices, but some are not. When the practice’s address and telephone number are set, contact local HMOs about becoming a panel member.

Hours of Practice Operation
Some managed-care organizations (MCOs) require, by contract, that a practice maintain certain hours. Barring that requirement, a practice is free to set its own hours.

Housekeeping
Housekeeping includes the following areas:

- Cleaning: Contract for a service, specifying how often cleaning is done and what is done. Three times a week is the minimum.
- Extermination: Twice a month is reasonable.
Snow removal: Businesses are usually responsible for removing snow or ice from the entranceway and parking lot.

Hazardous waste removal: Separate red bag trash cans need to be in each examination room. When those are filled, the bags are stored in a larger marked box or can. Hazardous waste disposal companies pick up at a monthly minimum rate.

Information Sheets for Patients
Collect effective patient handouts, videos, website references, and tapes on an ongoing basis. Display them in waiting rooms, bathrooms, or offices.

Insurance
Practices will need premises, professional liability, payroll, workers’ compensation, and employee health insurance.

Justifying NP Existence
Compile, on an ongoing basis, as many facts about the practice and clients as possible for use with insurers and other providers and for marketing purposes.

Laboratory Compliance
The laboratory, even for a small practice that does only urine dipsticks and pregnancy tests, must be approved by the state and federal governments. Obtain and fill out the paperwork needed to comply with state (State Laboratory Administration) and federal (CLIA) requirements. This means applications, fees, and, most likely, a designated laboratory director. In some states, the forms state that the laboratory director must be an MD, but on questioning, one may discover that a PhD in microbiology or biochemistry will be accepted as laboratory director.

**Equipment**
Buy a refrigerator with ice-making capabilities. Medications should be kept in a separate refrigerator from staff lunches and separate from specimens. Calibrate all equipment at least annually.

**Laundry**
Linens can be rented and laundered by an outside company, or paper gowns and drapes can be used. Laundries often require a monthly minimum charge, which may not be cost-effective for a new clinic.

**Library**
Some books are indispensable:
- Primary care handbook
- Dermatology book with pictures
- Lab test reference book
- Drug Facts and Comparisons or Physicians’ Desk Reference (or use Epocrates online)
- *Sexually Transmitted Disease Guidelines* for the current year from the Centers for Disease Control and Prevention
- *Guide to Antimicrobial Therapy* for the current year from the Centers for Disease Control and Prevention
- A current algorithm for healthcare maintenance and screening

**Malpractice Insurance**

Several companies sell malpractice insurance to NPs. Promotions for these companies are found in any of the journals for NPs.

**Marketing**

Consider generating newspaper articles about the opening of the practice, and ask for television coverage if an NP practice is a novel idea in your area. See that the practice is listed in provider directories. Consider purchasing advertisements in local newspapers. Consider having a website and using social media. Send direct mail or email flyers or have someone distribute flyers in local neighborhoods. Announce your practice to
colleague NPs, in NP publications, and at NP meetings, and ask for referrals. Notify local physicians of your practice and ask for referrals. When you refer patients to MDs, dentists, podiatrists, or optometrists, send a letter with the patient so that the provider knows that the referral comes from you.

**Nurses**
Family NPs are the most useful type of NP for a small clinic because they can see all age groups. In terms of noneducational assets, experience in primary care, productivity, compatibility, resourcefulness, and flexibility is essential.

Depending on patient needs, a practice may want to offer the services of addiction counselors and nurse psychotherapists.

**Researchers**
If there is a local nursing school, a connection for research expertise can be valuable.

**RNs, LPNs**
If payment for visits is not tied to NP or MD providers, a practice may find that visits to RNs or LPNs can be useful to patients.
On-Call Service
Twenty-four-hour on-call service is required by some insurers. Some practices use an answering machine that gives the telephone or beeper number of the person on call. Others use an answering service.

OSHA Compliance
The major requirements under the Occupational Safety and Health Act (OSHA) are wearing protective wear—gloves, gowns, masks, and goggles—when at risk for blood and other body fluid handling; collection of hazardous waste in separate, clearly marked trash cans; and proper disposal of hazardous waste.

In some states, the state administers the occupational health and safety program; other states have federal oversight. Inspectors generally concentrate on one of two areas: building safety or safe clinical practices.

Patients
Think about sources for new patients and ways to keep established patients. Word of mouth about good experience of care is the best form of advertising. Also, see “Marketing.”
**Pharmaceuticals Stock**

State law may control the NP’s authority to dispense medications and the conditions of dispensing. The practice may want to have a limited stock of commonly used pharmaceuticals, or if a pharmacy is nearby, the practice may not need to stock pharmaceuticals. As for stocking controlled substances, a practice that does so increases the risk of robbery and drug-seeking behavior on the premises.

**Samples**

Drug representatives supply many practices with samples of the newest and most expensive pharmaceuticals. However, if patients do not have pharmacy insurance, it is unlikely that they will be able to afford to keep taking the medications dispensed as a starter dose.

**Cost of Prescriptions**

Some reference books give comparison cost information on medications. Pharmacists are good sources of such information as well. Some insurers cover pharmaceuticals, and other insurers do not. Some patients are uninsured. Unless a patient has insurance that covers pharmaceuticals, patients will want to know the cost of prescriptions being written.
and the cost of alternative remedies. It is useful to establish a relationship with a pharmacy that can supply price lists for the prescribing NP.

**Storage**
Vaccines must be refrigerated, with a thermometer/thermostat keeping them at whatever temperature they require. Other noncontrolled medications should be kept out of public display. Controlled substances should be behind double locks. Records of on-hand supply and the dispensing of each dose should be kept.

**Physical Plant**
Consider the need for the following types of space:

- Conference room
- Play area for children
- Exam rooms
- Waiting area
- Laboratory
- Utility room
- Offices
- Storage

**Prescribing**
In some states, NPs need to obtain prescriptive authority separate from licensure. NPs who will be prescribing controlled substances need a DEA
number and a state CDS number. There is a fee for DEA registration. There also may be a fee for the state registration.

State law may require that NPs follow specific procedures when prescribing or dispensing medications. The state board of nursing is a good starting point for information about prescribing requirements.

**Purchasing**
Set up standing accounts with the following companies: medical supply company, pharmacy, medical waste disposal, answering service, telephone, utilities, medical equipment, equipment repair, printing, office supplies, and cleaning.

**Quality Assurance Plan**
Write a mission statement for the practice and post it. Set up a method of evaluation for staff, and conduct periodic self-evaluations. Adopt a set of clinical practice guidelines and a set of healthcare maintenance and screening guidelines. Do periodic chart reviews to see that the practitioners are following the clinic’s guidelines.

**Referrals**
Keep a referral directory, updated on a continuing basis, including names and phone numbers of referral sources, for the following:

- Cardiac evaluation
- Chest X-rays
- Counseling regarding unwanted pregnancy
- Dentistry
- Dermatology evaluation
- Drug and alcohol counseling
- Genetic counseling
- Gastrointestinal/genitourinary evaluation
- Head, eyes, ears, nose, and throat evaluation
- HIV testing
- Mammograms
- Marriage/family counseling
- Neurologic evaluation
- Orthopedic evaluation
- Psychiatric care
- Sexually transmitted infection screening
- Social work
- Surgical evaluation
- Counseling
- Protective services

**Regulatory Matters**
Every medical office lab needs either periodic inspection by CLIA or a letter of exception that states that an inspection is not required. For
information, call the state department of health’s laboratory division.

States do not necessarily require clinics to be licensed. However, the fire marshal will probably need to inspect and sign off on every public space.

**Reimbursement**
Develop a patient intake procedure by which the practice can ensure that insurance information is current. For example, check the patient’s insurance card, copy the card, and verify current coverage through a telephone number on the card. If the patient has no insurance, obtain his or her credit card, or work out the payment process. Collect copays.

Develop a fee schedule for visits and procedures, using appropriate CPT codes. Base the fee schedule on the income needs of the practice and the current reimbursements being paid by insurers.

**Security**
Most clinics do not need a security guard, but it is something to contemplate. Consider drafting a policy about after-hours use of the clinic by staff members. Develop a policy for handling cash
collected during the day. Do not keep narcotics or large sums of cash in the clinic.

Standard of Care
Consult books, journals, and other providers, and attend at least one conference a year.

Start-Up Funding
Write a business plan, or hire a consultant to write a business plan. Take the business plan to a bank and ask for a business loan. If turned down, contact the local Small Business Administration and request a loan.

Supplies
Disposable Medical Supplies
No matter what a clinic starts with, additional supplies always will be needed. Any clinic needs a running account with a medical supply company and a pharmacist, with a turnaround delivery time of no more than 48 hours.

Durable Equipment
Every state has durable medical equipment companies. Used medical equipment also is available through brokers or the web.

Stationery
The practice will need letterhead and envelopes, business cards, appointment cards, prescription pads, promotional brochures, and patient education brochures.

**Diagnostic Lab Supplies**
Laboratories supply specimen collection materials. State health departments often provide supplies for infectious disease testing and sometimes offer free diagnostic testing, with specimens sent by mail. Commercial labs provide all of the materials and vessels necessary to transmit lab specimens.

**Support Staff**
A receptionist is the most important employee, followed closely by the billing manager. Other staff to consider include a lab technician, a marketing specialist, a handyman, and a housekeeper.

**Volunteers**
States differ on whether volunteers are liable for their own acts or whether a clinic is responsible for the acts of volunteers. Managers should follow the same credentialing process in taking on volunteers as they do with employees.

**Waste, Hazardous**
Red plastic containers specially made for sharp instruments and needles and clearly marked as hazardous waste containers are required by law. Sharp instruments and needles are deposited in the red containers, which then go in boxes supplied by a waste disposal company. These boxes should be picked up monthly, at a minimum. Diapers and bloody materials are deposited in red bags. The red bags are tied and put into larger boxes. Personnel who pick up the hazardous waste must be certified in that area; that is, a staff person cannot cart it away. Therefore, clinics must hire waste disposal services.

**Written Agreement**
In many states, each NP must have a written collaborative agreement with a physician specifying the scope of practice of the NP, what kind of oversight the physician will give, and the site of the practice. The agreement must be signed by each party and approved by the board of nursing.

**Yellow Pages Advertising**
Advertising is expensive, yet for some practices it will be the major source of clients. It is a budgetary item to be considered and balanced among other necessary expenditures.
Appendix 11-B: Sample Independent Contractor Agreement

NOTE: This is a sample contract for a situation in which an NP is contracting for NP services with a business entity. It should not be used as a template because every arrangement is different and thus needs its own contract. Consult an attorney to draft a contract to suit a particular arrangement.

THIS AGREEMENT made __________, 2016, by and between Jane Doe, an individual, hereinafter referred to as “the Nurse Practitioner,” and Heathrow School, a nonprofit educational institution in Maryland, hereinafter referred to as “the School.”

Recitals

1. The School is an educational institution.
2. Jane Doe is an individual Nurse Practitioner certified to practice in Maryland.
3. The School has a health center, hereinafter referred to as “the Center,” which serves the needs of enrolled students when school is in
session. The purposes of the health center are to (a) improve the health of children and adolescents by providing comprehensive physical and mental health services and (b) work with school faculty, parents, and students to create health-promoting environments.

4. The school year is September 5 to June 15, not including December 12 to January 4 and March 15 to 27.

NOW, THEREFORE, the parties agree as follows:

1. The School, through the Nurse Practitioner, will offer the following services: general primary health care; mental health, psychosocial, and family counseling; drug and alcohol abuse programs; treatment of minor injuries; sexuality education and counseling; gynecological exams and treatment of sexually transmitted infections; AIDS education and counseling; nutrition education and weight reduction; health education; routine physical exams (including sports physicals); diagnosis and treatment of acute and chronic illnesses; referrals for illnesses and injuries not suitable for treatment in the school clinic; pregnancy
tests, early periodic screening, and development testing; case management and support services for mainstreaming and preventing complications for children who have chronic health problems and special healthcare needs; and sick care for students with minor injuries and illnesses.

2. The School will have the following responsibilities for operations of the Center:
   
   2.1. The School shall maintain a physical plant, to consist of two rooms, including two telephone lines, copy machine, fax machine, desk, lamps, exam table, sink, and file cabinets, all in safe working order.

   2.2. The School shall arrange and pay for disposal of hazardous waste, compliance with state and federal requirements for health centers and laboratories, security, utilities, cleaning, and durable medical equipment and supplies.

   2.3. The School will arrange and pay for physician consultation services if needed.

   2.4. The School will maintain storage and confidentiality of medical records
to the extent required by state law.

2.5. The School will bill for services provided by the Nurse Practitioner.

3. The Nurse Practitioner will have the following responsibilities:

3.1. Maintain her own certification, licensure, malpractice insurance, and continuing education.

3.2. Provide her own tools and examination instruments.

3.3. Pay her own taxes, Social Security, Medicare, workers’ compensation, and unemployment contributions.

3.4. Set her own hours within the following parameters: She must be on premises 5 hours on school days, with a schedule prearranged and posted.

3.5. Provide on-call services for school hours when she is not on-site.

3.6. Attend two school meetings per year.

3.7. Report to school authorities any student who is a danger to self or
others in accordance with the state laws regarding patient privacy.


3.9. Maintain the accepted standard of care of school-aged patients.

3.10. Follow up outstanding diagnostic and treatment problems even if school has gone out of session.

4. Jointly, the parties will:
   4.1. Establish procedures to adopt protocols and standards to evaluate quality and appropriateness of care provided at the health center.

   4.2. Work cooperatively to generate reports and analyses required as a condition of grant or contract funding of the health center and submit to each other data and other information required by regulatory or funding agencies.

   4.3. Work in concert to ensure compliance with all regulatory requirements relating to clinical services.
5. Term and termination.

5.1. This Agreement shall become effective September 1, 2016, and continue through June 15, 2017, and will be renewed annually, for a term beginning September 1. By agreement of the parties, this Agreement shall be amended to be effective for any subsequent school years in which the parties agree to continue the Agreement with compensation to be adjusted in such years in accordance with the procedure specified in clause 7.1.

5.2. Either party may terminate this Agreement upon the material default of the other party, provided that the party in default is given at least five (5) business days’ notice of intention to terminate and fails to cure the default, or, if the default is such that it cannot be cured within five (5) business days, fails to undertake substantial efforts to begin cure and to continue such efforts until the default is cured. For this purpose, “business day” is defined as a day the School is open for regular business.
5.3. Either party may terminate this Agreement for any cause by giving the other party at least six (6) months’ written notice.

5.4. If the parties agree that there are irreconcilable differences regarding the standard of care to be upheld at the health center, either party may give the other party thirty (30) days’ notice of termination.

5.5. Either party may terminate this Agreement immediately if its performance becomes impossible and is expected to remain impossible for an indefinite period of time as a result of a cause described in clause 6.12.

6. Administrative and legal matters.

6.1. The School shall hold title to any equipment purchased by it. The Nurse Practitioner shall hold title to any equipment purchased by the Nurse Practitioner.

6.2. The parties shall comply with all federal, state, and local laws, ordinances, rules, and regulations that
are applicable to the operation of the Center.

6.3. Amendments to this Agreement must be stated in writing and executed by the authorized officials of the School and the Nurse Practitioner.

6.4. The relationship of the School and the Nurse Practitioner is that of independent contractor. Nothing in this Agreement shall be deemed to create or constitute a partnership, joint venture, employment, or agency relationship between the parties.

6.5. The parties agree that each is responsible for the actions and failures to act on the part of each party’s own employees and agents in the performance of this Agreement and that each party shall have no responsibility for costs, judgments, or obligations resulting from or in any way connected with the actions and failures to act on the part of the other party’s employees.

6.6. All notices, official correspondence, and requests for
permission required by this Agreement to be sent from one party to the other shall be sent in writing by first-class mail, return receipt requested, or by any overnight courier or same-day delivery service that provides a receipt of delivery, to the address set forth in this paragraph or to such other address as a party may establish in the future by proper notice:

For the School:

Barbara Johnson
Headmistress
Heathrow School
Fulton, MD 20759

For the Nurse Practitioner:

Jane Doe
11 Janeway Ct.
Fulton, MD 20759

6.7. Each party represents that it has authority to execute and deliver this Agreement and to perform its obligations hereunder and that all
necessary approvals for execution of this Agreement have been obtained.

6.8. This Agreement is not assignable, in whole or in part, by either party without the prior written consent of the other party.

6.9. This Agreement, the rights and obligations of the parties, and any claim or dispute arising from this Agreement shall be governed by and construed in accordance with the laws of Maryland.

6.10. If any part of any provision of this Agreement becomes invalid or unenforceable under applicable law, that provision shall be ineffective to the extent of the invalidity or unenforceability only, without in any way affecting the remaining provisions of this Agreement.

6.11. Any payment due the School that is rendered more than fourteen (14) calendar days after the date due shall accrue interest at the rate of ten percent (10%) per annum from the date due until the date paid.
6.12. Neither party shall have liability for breach of contract or delay in performance of its contractual responsibilities if the party is unable to perform required services under this Agreement as the result of performance becoming impossible due to governmental regulation, request, or order or circumstances beyond the reasonable control of the party, including, without limitation, acts of God, fire, flood, accident, labor strike, war or civil disobedience, inability to obtain supplies, or interruption of utility services, where such circumstances make it impossible to perform or to perform in a timely manner.

6.13. A party's waiver of any right under this Agreement, including without limitation the right to terminate for default, shall not be construed as an agreement to continue such waiver indefinitely or to grant a waiver in the event of a repetition of the action or omission in question.

7. Payment.
7.1. The School agrees to pay Nurse Practitioner $81,000 per year, payable in 10 payments of $8,100, due on the first of the month starting September 1 and continuing through June 1.

7.2. The School agrees to mail payments to Nurse Practitioner at the address listed in clause 6.6.

IN WITNESS WHEREOF, the parties, by their undersigned representatives, have caused this Agreement to be executed.

Barbara Johnson

For Heathrow School

Date __________

Jane Doe, NP

Date __________
Appendix 11-C: Sample NP Business Plan

The following is an example of a basic business plan for a very simple NP practice. Any individual who is considering starting a business should research the income and expenses of the business to determine whether it has potential for success. A business plan can be much more detailed than this example and should include a balance sheet. An NP should engage a business consultant to write or review his or her business plan, using research and projections supplied by the NP. An NP also should engage an accountant to compute a balance sheet and other computations based on the NP’s research of income and expenses. The information given here is what an NP should expect to supply to the business consultant and accountant.

Assumptions

Assume that the business is a well-women clinic in a small town.

The business will be staffed by one NP, who will be assisted by a receptionist and a medical assistant.
The hours are noon to 4:00 p.m., Monday to Friday, and 9:00 a.m. to 1:00 p.m. on Saturdays.

The NP starting the practice has 15 years of experience as an OB/GYN NP but will not do obstetrics. She will refer pregnant patients to her collaborator.

Assume that the business is in a state where a written physician collaboration agreement is needed. The physician collaborator will be paid for reviewing and signing the written agreement and being available for consultation at the discretion of the NP.

The NP has elected not to bill insurance. The services will be provided on a fee-for-service, payment-at-time-of-service basis. The practice will accept credit cards. The fee for an exam is $85. Cultures (i.e., gonorrhea, chlamydia, and herpes) and HIV tests will be sent to the state public health lab, which will do the tests at no charge. The clinic will do urine pregnancy tests and wet mounts on-site at charges of $20 and $25, respectively. Pap smears will be read by a local laboratory, which has agreed to charge $30 each. If blood work is needed, the blood will be drawn by the NP and sent to a
local laboratory. Bills for any blood work are sent from the laboratory directly to the patient.

Main Street Well-Women Care

111 Pinetree Lane

Bristol, CT 06010

(300) 333-1212

Jane Jones, CRNP

July 30, 2016

<table>
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<th>Executive Summary</th>
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<td>Mission Statement</td>
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<td>Background Information on the Business</td>
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<td>Objectives</td>
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<td>Capital Requirements</td>
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<tr>
<td>Product Strategy</td>
<td>5</td>
</tr>
<tr>
<td>Current Product/Service</td>
<td>5</td>
</tr>
<tr>
<td>Research and Development</td>
<td>5</td>
</tr>
<tr>
<td>Key Factors in Delivery of Service</td>
<td>6</td>
</tr>
</tbody>
</table>
### Executive Summary

Main Street Well-Women Care (WomenCare) is a new business, to open January 2, 2017. The business will offer women who are essentially healthy routine annual gynecologic examinations, Pap smears, diagnosis and treatment of gynecologic infections, birth control, and pregnancy tests.
With the closing of Bristol Planned Parenthood in June 2016 due to financial and management restructuring of that organization, there has been a lack of well-woman services in Bristol. Not only is the Hartford office of Planned Parenthood inconvenient to the women of Bristol but also that office is not prepared to handle the volume of patients from Bristol.

WomenCare will replace the services of the Bristol Planned Parenthood office and will market itself differently so that women who would not go to Planned Parenthood will visit WomenCare. WomenCare will be located in a storefront location next to the town’s main grocery store. WomenCare will offer basic gynecologic services, such as annual exams, breast exams, infection checks, prescription of birth control, and pregnancy tests. There will be no surgical services, no prenatal services, and no abortion services. Visits will be by appointment and on a walk-in basis.

Jane Jones, CRNP, is the owner and practitioner of WomenCare. Ms. Jones is an OB/GYN nurse practitioner, certified nationally and licensed in Connecticut. Ms. Jones has 15 years of experience providing
primary care to women at Planned Parenthood of Hartford. John Evans, MD, an obstetrician/gynecologist in Hartford, will provide consultation and sign the written agreement, as is required by Connecticut law for nurse practitioner practice. Patients who need surgery or further consultation or who are pregnant will be referred to Dr. Evans or another obstetrician/gynecologist of the patient’s choice.

The business strategy of WomenCare is to offer low-cost, high-quality primary care women’s health services in a convenient storefront setting. WomenCare will operate on a cash or credit card payment basis, with fees paid at time of service. WomenCare will not bill insurance companies. The strategy underlying this payment system is that avoiding the clerical work necessary to establish provider status and bill multiple insurers will allow WomenCare to offer services at a rate below that of other local providers. Furthermore, WomenCare’s services will be performed by a nurse practitioner, whose services can be offered at less cost than a gynecologist’s services.
The charge for a routine annual examination from a private physician in Bristol is $140. WomenCare will offer the exam for $85 and therefore will be attractive to uninsured women. Forty percent of the women in Bristol do not have health insurance (“Uninsured Lack Care in Area,” *Hartford Courant*, January 2, 2015, p. 2). Women who are insured may visit WomenCare, pay the bill, and attempt to obtain reimbursement from their insurer.

Start-up funding is needed in the amount of $50,000.

**Mission Statement**
To provide convenient, high-quality, affordable primary women’s healthcare services to generally healthy women aged 13 and over.

**Background Information on the Business**
During her 15 years of practice in Bristol, Jane Jones has established a following of patients. She is now working at the Hartford Planned Parenthood but will leave that position on December 30 to open WomenCare. The location for WomenCare has been secured. An agreement has been
reached with the consulting physician. Opening publicity has been planned.

Hours will be noon to 4:00 p.m., Monday to Friday, and 9:00 a.m. to 1:00 p.m. on Saturdays, 50 weeks of the year. Patients will be scheduled for half-hour appointments. Therefore, the volume will be 48 visits per week, or 2,400 visits per year. The charge will be $75 per visit, $20 for a pregnancy test, and $25 for a wet mount.

**Objectives**

1. Secure start-up funding by October 15, 2016.
2. Sign lease on December 1, 2016.
5. Hire two employees to start December 26, 2016.

**Capital Requirements**
Start-up funding of $50,000 is needed to cover initial rent, furnishings, equipment, legal fees, initial salaries, cleaning, and other business expenses. It is not anticipated that further business loans will be needed unless expansion occurs.

Management Team
Jane Jones is the provider/manager.
Because there is no billing of insurers, there is little need for a professional office manager. Ms. Jones will be assisted during office hours by a part-time medical assistant. A receptionist will cover the front desk during office hours.

Attorney Carolyn Buppert will provide legal services, including contracts between Ms. Jones and Dr. Evans, review of the lease, and laboratory contracts; filing of the CLIA application; and employment contracts for the staff.

Accountant James Edwards will provide accounting services. Payroll will be handled by PayCheck, a local payroll service.

Product Strategy
Every woman needs a yearly gynecologic exam. The strategy of WomenCare is to
provide that service in a convenient neighborhood location at a reasonable cost through a provider already well known to many neighborhood residents. Women will be reminded of WomenCare’s services every time they visit the grocery store, which is located in the same strip shopping center as WomenCare.

**Current Product/Service**
There is no current service by WomenCare. The services to be offered by WomenCare when it opens are currently offered at a higher cost by three local obstetrician/gynecologists, who are located in a less convenient location in the Bristol Medical Park. Similar services to WomenCare are also offered currently through Planned Parenthood of Hartford, which is 30 miles away from the proposed WomenCare location.

**Research and Development**
Ms. Jones surveyed the patients who visited Planned Parenthood of Bristol in the final 3 months of that clinic’s operation. Two hundred patients responded. Patients responded that they did not have an alternative provider in mind at the time of the
survey, that they were interested in continued service from Ms. Jones, and that they were primarily in need of the following services:

- Annual gynecologic exam (100% of patients)
- Infection checks, approximately once a year (25% of patients)
- Exam for menstrual pain or dysfunctional menses, approximately once every 3 years (10% of patients)
- Renewal of birth control pills every 6 months (20% of patients)
- Pregnancy test approximately once every 6 months (10% of patients)

Planned Parenthood of Bristol had 800 patients at the time the center closed.

A survey conducted at the local YWCA in April 2014 of 200 women attending a seminar for unemployed women revealed that 50% of the women would visit a women’s health office every year if the cost were $75 or less. Of women surveyed, 75% stated that they would prefer a woman provider, and 98% were amenable to having their primary care services provided by a
nurse practitioner. Two percent preferred a physician.

Of the five internists in Bristol, only three do gynecologic examinations. Two internists refer their patients to gynecologists for annual examinations. Ms. Jones met with the two internists who do not do gynecologic exams and asked whether they would consider referring to WomenCare. Both internists agreed to refer “some” of their patients to WomenCare.

**Key Factors in Delivery of Service**

Key factors distinguishing WomenCare that will contribute to its success are:

- Convenience
- Service by one well-known nurse practitioner
- Reasonable cost

**Definition of the Market**

The market for WomenCare is all females aged 13 and over living in Bristol, Connecticut, or within a 15-mile radius of WomenCare.

**Analysis of the Market**
Fourteen thousand people live in Bristol. Approximately 35% of Bristol’s residents are females aged 13 and over. The potential market in Bristol, therefore, is 4,900 people. If WomenCare acquired one-half of the potential market, WomenCare would have 2,450 patients, each visiting at least once per year.

Southington and Plainville are neighboring communities with 10,000 and 15,000 residents, respectively. If 35% of Southington and Plainville residents are women over 13 years of age and 10% of the eligible population visits WomenCare, then WomenCare will have an additional 875 patients who will visit at least once a year.

**Profile of Clients**

There are three subsets of “average patients” who will patronize WomenCare.

One subset of clients will be sexually active females of childbearing age who are employed without health benefits or who are unemployed. Such clients will be seeking birth control services for some portion of their childbearing years and will be seeking diagnosis of symptoms that they suspect are due to a sexually transmitted infection.
A second set of average patients will be menopausal women who will need attention to menopause-related symptoms and hormone replacement therapy or alternative therapies.

A third subset of patients will be teenagers who are seeking care for complaints that they would prefer not to discuss with their parents. These patients are considered emancipated under Connecticut law for issues of birth control and sexually transmitted infection screening, and parental consent is not required.

**Competition**

There are three obstetrician/gynecologists in Bristol. Two are male, and each has been in practice for approximately 20 years. The third is female and has been in practice approximately 5 years. Approximately 50% of the practice of each physician is obstetric care. The two male physicians have approximately 3,000 patients each. The female physician has 2,000 patients. The physicians draw patients from Southington, Plainville, and Worthington.

WomenCare could be expected to draw approximately 500 patients from the
physicians. These patients would be those who are uninsured and do not want to pay $175 per visit.

Planned Parenthood of Hartford offers the same services proposed by WomenCare and therefore is a competitor as well. However, because Ms. Jones practiced in Bristol with Planned Parenthood until June 2015 and now practices at the Planned Parenthood in Hartford, it is reasonable to expect that Ms. Jones has former patients in Bristol and that a portion of the Hartford patients will visit WomenCare.

**Business Risks**
The biggest risk is insufficient patient visits, primarily because of inability of patients to afford the $85 fee plus lab fees when necessary. Another risk is the withdrawal of Dr. Evans as collaborator. This risk is minimized for the first year, because Dr. Evans has agreed to sign a yearlong contract.

**Plan for Marketing the Practice**
A direct-mail announcement will be sent to all of Ms. Jones’s former patients at Bristol Planned Parenthood. Ms. Jones will email
individuals in her own address book to announce the opening. Ms. Jones will enlist several of her trusted colleagues to email their contacts about WomenCare. Flyer-type advertisements will be posted at the grocery stores and on the high school and community college bulletin boards. WomenCare will have a website, to include a video of Ms. Jones talking about her approach to care and welcoming new patients.

Because of WomenCare’s storefront location next to the grocery store, WomenCare will be seen by almost everyone in the neighborhood. An “Opening Soon—WomenCare” sign will appear on December 1, 2016, at the location.

Dr. Evans has agreed to refer patients to WomenCare when they are uninsured and cannot afford the $140 he charges.

**Marketing Strategy**
The strategy for marketing WomenCare is to get a core number—approximately 250 patients—through direct mail to former patients of Ms. Jones at the now-defunct Planned Parenthood of Bristol, through the flyers at the store and schools, and through
the “Opening Soon” sign at the business location. It is anticipated that each of the core 250 patients will tell one other potential patient of WomenCare in the first 3 months of operation and that one-half of the word-of-mouth contacts will visit. Therefore, by month 4, WomenCare will have seen approximately 375 women. Each quarter, it is estimated that a patient will tell at least one friend, neighbor, or family member about WomenCare and that a significant portion of those contacts will visit within the year.

**Advertising and Promotion**

No advertising will be purchased. However, the WomenCare sign at the location in the strip shopping center will advertise the business.

Ms. Jones and her staff will attempt to make every patient a permanent patient through close attention to personal service and individual needs.

One Saturday a month will be “Teen Day,” when female teenagers will be encouraged, through an announcement posted on the door of the business location, to come and ask any question of Ms. Jones, free of charge. Through this promotion, teenage
girls will begin to establish a relationship with Ms. Jones so that when they are in need of services, they will think of WomenCare.

**Publicity Strategies**
Each visitor to WomenCare will receive a business card that includes the services provided and their prices, along with the usual business card information.

Ms. Jones will do one presentation per year at the high school on a topic of interest to female high school students and one presentation per year at the local college on a topic of interest to female college students.

**Financial Plan**

**Table 11-1** Projected Operating Expenses, Year 1

<table>
<thead>
<tr>
<th>Expense</th>
<th>Cost</th>
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</thead>
<tbody>
<tr>
<td>Rent</td>
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<td>Utilities</td>
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</tr>
<tr>
<td>Supplies</td>
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</tr>
<tr>
<td>Continuing education</td>
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</tr>
<tr>
<td>Cleaning</td>
<td>$6,000</td>
</tr>
<tr>
<td>Description</td>
<td>Amount</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Insurance</td>
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<td>Hazardous waste disposal</td>
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<td>MD consultant</td>
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<tr>
<td>Total nonsalary expenses</td>
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</tr>
<tr>
<td>Salaries, annual</td>
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<tr>
<td>NP, 0.6 FTE</td>
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</tr>
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<td>Medical assistant, 0.6 FTE</td>
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</tr>
<tr>
<td>Receptionist, 0.6 FTE</td>
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<tr>
<td>Social Security/Medicare contributions for 1.8 FTEs</td>
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</tr>
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<td>Total salary expenses</td>
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<td>Total operating expenses</td>
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</tr>
<tr>
<td>Expenses of start-up (equipment, attorney, licenses, etc.)</td>
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</tr>
</tbody>
</table>

*Abbreviation: FTE, full-time employee.*

**Table 11-2** Projected Expenses, Month by Month, Year 1 (in Dollars)
Table 11-3 Projected Income, Month by Month, Year 1 (in Dollars)

<table>
<thead>
<tr>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
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<td>2,000</td>
<td>2,000</td>
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<td>Supplies</td>
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<td>500</td>
<td>500</td>
<td>500</td>
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<td>1,000</td>
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<td>Expenses/mo</td>
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<td>18,358</td>
<td>18,358</td>
<td>18,358</td>
<td>18,358</td>
<td>18,358</td>
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<td>18,358</td>
<td>18,358</td>
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<tr>
<td>YTD expenses</td>
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<td>91,790</td>
<td>109,148</td>
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Table 11-4 Projected Income, Month by Month, Year 2 (in Dollars)

<table>
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<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
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<th>Jun</th>
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<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits</td>
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<td>80</td>
<td>100</td>
<td>110</td>
<td>120</td>
<td>120</td>
<td>120</td>
<td>120</td>
<td>120</td>
<td>120</td>
<td>120</td>
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<tr>
<td>Test, preg.</td>
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<td>15</td>
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<td>20</td>
<td>20</td>
<td>25</td>
<td>30</td>
<td>30</td>
<td>40</td>
</tr>
<tr>
<td>Tests, wet mount</td>
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<td>15</td>
<td>20</td>
<td>25</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>25</td>
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<td>8,625</td>
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<td>Projected operating expenses, year 1</td>
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<td>Loan payments, year 1</td>
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Table 11-5 Projected Income, Month by Month, Year 3 (in Dollars)

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<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
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</thead>
<tbody>
<tr>
<td>Visits</td>
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<td>200</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>Test, preg.</td>
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<td>80</td>
<td>80</td>
<td>80</td>
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<td>80</td>
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<tr>
<td>Tests, wet mount</td>
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<td>50</td>
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<td>Projected operating expenses, year 2*</td>
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<td>Total expenses, year 2</td>
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<tr>
<td>Profit, year 2</td>
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</tbody>
</table>

*It is projected that operating expenses will increase at 5% per year.
Payback Plan
Loan of $50,000 on October 1, 2016.

Repay nothing until January 1, 2017, at which time payments will be made as follows:

<table>
<thead>
<tr>
<th>Period</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1 to December 31, 2017</td>
<td>$800/month</td>
</tr>
<tr>
<td>January 1 to December 31, 2018</td>
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<tr>
<td>January 1 to December 31, 2019</td>
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<tr>
<td>January 1 to December 31, 2020</td>
<td>$1,500/month</td>
</tr>
<tr>
<td>Total repaid</td>
<td>$51,600</td>
</tr>
</tbody>
</table>
Appendix 11-D: Sample Professional Services Agreement

NOTE: This is a sample contract between an NP and a physician collaborator. It is not meant to be a template. Each agreement between two parties is different, and participants should consult an attorney to determine the best contract to suit their particular agreement.

THIS AGREEMENT ("Agreement"), effective ____________, 20__, is between C. B. Bosco, CRNP, PC, an Indiana professional corporation (the “Nurse Practitioner”), and George Oaks, MD, PC, an Indiana professional corporation (the “Physician”).

RECITALS

WHEREAS, the Physician is engaged in the practice of medicine in Indiana;

WHEREAS, the Nurse Practitioner is engaged in practice of a nurse practitioner in
WHEREAS, the Nurse Practitioner is required by law to have a collaborative association with a physician;

WHEREAS, the Physician wishes to collaborate with the Nurse Practitioner;

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is acknowledged, the parties agree as follows:

1. Definitions
   1.1. “Contract Year” shall mean the twelve (12)-month period following the effective date of this Agreement. Thereafter, each additional twelve (12)-month period during the term or any successive term shall constitute a Contract Year.

   1.2. “Nurse Practitioner” shall mean C. B. Bosco, located at 102 Goldleaf Ave., Suite 2, Jasonville, IN.

   1.3. “Physician” shall mean George Oaks, located at 102 Goldleaf Ave., Suite 3, Jasonville, IN.
1.4. “Term” shall mean the period from ____________, 20__, through ____________, 20__, unless sooner terminated or extended as provided herein.

2. Representations and warranties
   2.1. The Nurse Practitioner represents:
   
   2.1.1. That she holds a current license from the state of Indiana as an Adult Nurse Practitioner;
   
   2.1.2. That her license or certificate to practice as a registered nurse or nurse practitioner in Indiana has never been revoked, suspended, restricted, or subject to possible disciplinary action;
   
   2.1.3. That her privileges to practice as a nurse practitioner at a hospital or other healthcare facility have never been revoked, suspended, restricted, or subject to possible disciplinary action;
   
   2.1.4. That there has never been entered against the Nurse
Practitioner a final judgment in a malpractice action and that there has never been an allegation of malpractice by the Nurse Practitioner that has been settled by payment to the plaintiff;

2.1.5. That the Nurse Practitioner has never had malpractice liability insurance canceled, restricted, or not renewed;

2.1.6. That the Nurse Practitioner has never been found guilty of a crime of any nature;

2.1.7. That the Nurse Practitioner has never been reported to any state or federal healthcare program for alleged violations of state or federal health laws or regulations or been found by such program to be in violation of such laws or regulations.

2.2. The Physician represents:
2.2.1. That the Physician holds a current license from the State of Indiana as a physician;

2.2.2. That the Physician’s license to practice as a physician in Indiana has never been revoked, suspended, restricted, or subject to possible disciplinary action;

2.2.3. That the Physician’s privileges to practice as a physician at a hospital or other healthcare facility have never been revoked, suspended, restricted, or subject to possible disciplinary action;

2.2.4. That the Physician has never been found guilty of a crime of any nature;

2.2.5. That the Physician has never been reported to any state or federal healthcare program for alleged violations of state or federal health laws or regulations or been found by
such program to be in violation of such laws or regulations.

3. Duties of the Nurse Practitioner. The Nurse Practitioner shall:

3.1. Practice the profession of a nurse practitioner in accordance with the laws and regulations governing the practice of a nurse practitioner in Indiana.

3.2. Provide all medical services within reasonable and accepted medical standards and in conformance with all requirements that may be imposed from time to time by the applicable health licensing boards.

3.3. Maintain neat, timely, and legible medical records for all patients evaluated and treated by the Nurse Practitioner.

3.4. Maintain Nurse Practitioner’s own malpractice insurance; maintain a license to practice as a nurse practitioner in Indiana in good standing during the term of this Agreement or any renewal thereof; maintain nurse practitioner board certification; and maintain nurse practitioner continuing
education credits according to the prevailing standard, which is a minimum of seventy-five (75) credits every five (5) years.

3.5. Maintain her own schedule of patients.

3.6. Pay the Physician a sum of $5,000 per contract year, with one payment made on the date this Agreement is signed and one payment made six (6) months after the signing of this Agreement, plus $200 per hour for consultation time initiated by the Nurse Practitioner.

3.6.1. Consultation time includes telephone consultations; in-person, face-to-face consultations; and review of charts.

3.6.2. The minimum segment billed for a consultation is ten (10) minutes.

3.6.3. Nurse Practitioner will pay consultation fees monthly, within thirty (30) days of receiving a bill from the Physician.
3.6.4. When patients are admitted to a hospital, Nurse Practitioner shall pay Physician for consultation time until such time as the patient is admitted. After hospital admission, Physician may bill patient or patient’s insurance company for services provided the patient in the hospital until such time as the patient is discharged.

4. Duties of the Physician. The Physician shall:

4.1. Respond to a telephone call from Nurse Practitioner within two (2) hours unless Nurse Practitioner characterizes the call as an emergency, in which case the Physician will respond to a call within fifteen (15) minutes.

4.2. Keep a record of consultations and bill the Nurse Practitioner once a month.

4.3. Sign the Nurse Practitioner’s written agreement as required by Indiana law.

4.4. Meet with the Nurse Practitioner once a month, for one-half hour, for
discussion of clinical guidelines and management of difficult patients.

4.4.1. Agree that the meeting shall take place at a mutually agreed upon location, which may vary from time to time.

4.4.2. Agree that payment for monthly meeting time is included in the $5,000 per contract year that Nurse Practitioner pays Physician.

4.5. Agree to conform, in Physician’s consultations, to the standard of care of a reasonably prudent Physician practicing as an internist in suburban Indiana.

4.6. Assist Nurse Practitioner, to the best of Physician’s ability, in any other requirements for physician collaboration that may arise and that are necessary to conform to the laws and regulations governing the practice of a nurse practitioner in Indiana.

4.7. Agree not to bill a patient’s insurance company directly for any
consultative services Physician provides a nonhospitalized patient of the Nurse Practitioner unless the Nurse Practitioner and Physician agree that the Physician, and not the Nurse Practitioner, will bill the services.

4.8. Bill a patient of the Nurse Practitioner or the patient’s insurance company for visits to such patient while the patient is hospitalized.

4.9. Return the care of hospitalized patients of the Nurse Practitioner to the Nurse Practitioner after discharge from the hospital.

4.10. Cosign charts where the Nurse Practitioner and Physician are comanaging patients.

4.11. Maintain Physician’s own malpractice insurance; maintain a license to practice as a physician in Indiana in good standing during the term of this Agreement or any renewal thereof; maintain physician board certification; and maintain physician continuing education credits according to the prevailing standard.
4.12. Maintain hospital admitting privileges at at least one hospital within a 20-mile radius of the Nurse Practitioner’s office.

4.13. Physician agrees that this is not an employment relationship.

4.13.1. Physician agrees that Physician is responsible for federal and state income taxes on any amount paid to Physician by Nurse Practitioner; for Physician’s own health insurance, workers’ compensation, and unemployment insurance; and for Physician’s own expenses of practice.

5. Term

5.1. The Term of this Agreement shall be from __________, 20__, and shall automatically renew for successive one (1)-year terms unless terminated earlier as provided herein.

5.2. In the event that either party intends not to renew, such party shall give the other party ninety (90) days’
notice of its intent not to renew, and the term or renewal term shall end upon the completion of the applicable contract year.

6. Termination

6.1. The Agreement shall be terminated immediately upon the happening of any of the following events:

6.1.1. The death of Nurse Practitioner or Physician;

6.1.2. Nurse Practitioner is legally disqualified or restricted in Nurse Practitioner’s ability to render professional medical services in the State of Indiana as a nurse practitioner, or disciplinary action is taken against Nurse Practitioner’s license in any other jurisdiction. For purposes of this section, the lapse of license for nonpayment of applicable licensing fees in a jurisdiction other than Indiana shall, by itself, not be considered disciplinary action;
6.1.3. Physician is legally disqualified or restricted in his ability to render professional medical services in the State of Indiana as a physician, or disciplinary action is taken against Physician’s license in any other jurisdiction. For purposes of this section, the lapse of license for nonpayment of applicable licensing fees in a jurisdiction other than Indiana shall, by itself, not be considered disciplinary action;

6.1.4. Physician’s loss or restriction of staff membership or professional privileges at any hospital or healthcare facility at which Physician has privileges, unless such loss or restriction was due to the occasional violation of the facility’s record-keeping requirements or Physician shall have previously notified Nurse Practitioner that such loss or restriction will not terminate this Agreement;
6.1.5. Physician’s disability as defined by federal or state law, or to the extent that the Physician cannot reasonably or competently perform the Physician’s duties;

6.1.6. Nurse Practitioner’s disability as defined by federal or state law, or to the extent that Nurse Practitioner cannot reasonably or competently continue to practice;

6.1.7. Ninety (90) days after Nurse Practitioner or Physician gives written notice to the other of termination without cause;

6.1.8. At any time by mutual agreement of the parties;

6.1.9. Nurse Practitioner’s material breach of this Agreement, provided, however, that if Nurse Practitioner’s breach of this Agreement is of a type and nature that may be cured, Nurse Practitioner shall have the opportunity
immediately to cure breaches to the reasonable satisfaction of the Physician;

6.1.10. Physician’s material breach of this Agreement, provided, however, that if Physician’s breach of this Agreement is of a type and nature that may be cured, Physician shall have the opportunity immediately to cure breaches to the reasonable satisfaction of the Nurse Practitioner;

6.1.11. Upon Physician’s conviction of a crime;

6.1.12. Upon Nurse Practitioner’s conviction of a crime;

6.1.13. Upon adjudication that Nurse Practitioner is insane or determined to be legally incompetent;

6.1.14. Upon adjudication that Physician is insane or
determined to be legally incompetent;

6.1.15. In the event that professional malpractice insurance for Nurse Practitioner is denied or lost or is limited by restriction or endorsement;

6.1.16. In the event that professional malpractice insurance for Physician is denied or lost or is limited by restriction or endorsement;

6.2. Upon termination of this agreement, the original records of patients followed by Nurse Practitioner or in Nurse Practitioner’s office are understood by the parties to be the property of Nurse Practitioner.

7. Notices
7.1. All notices provided in this Agreement shall be directed to the parties in writing by registered or certified mail, return receipt requested, or by hand delivery at the following addresses.
8. General terms

8.1. Applicable law. This Agreement shall be construed and enforced under Indiana law.

8.2. Nonassignment.

8.2.1. The Physician shall not be entitled to assign any of the benefits or burdens imposed on the Physician hereunder.

8.2.2. The Nurse Practitioner shall not be entitled to assign any of the benefits or burdens imposed on the Nurse Practitioner hereunder.
8.3. Binding effect. This Agreement shall be for the benefit of and be binding upon the parties hereto, their respective representatives, heirs, assigns, and successors-in-interest.

8.4. Execution. This Agreement shall be executed in duplicate, and each executed copy shall constitute an original, but the two copies shall be deemed one and the same instrument, and this Agreement shall not be modified or changed, except in writing, signed, and acknowledged by the parties hereto.

8.5. Entire agreement. This Agreement contains the entire understanding between the parties hereto and supersedes any prior written or oral agreement between the parties. There are no representations, agreements, or understandings, oral or written, between or among the parties hereto relating to the subject matter of this Agreement that are not fully expressed herein.

WITNESS the following signature and seals:
Nurse Practitioner: ______________________

Date: ___________________________________

Physician: _______________________________

Date: ___________________________________
Chapter 12: Lawmaking and Health Policy

Health care is regulated for the public good, to ensure quality to a public that is powerless to assert quality control as individuals. That is the theory, at least. In the real world, health care is regulated for quality reasons, to increase access and save money, and because professional groups lobby for regulations that support their profession and businesses lobby for regulations that help their businesses. Regulation is imposed through statutes, regulations, and policies and, when a statute or regulation is challenged in court, through the judicial system.

The Legal Process
Statutes
A statute is a law enacted by a state legislature or Congress. Laws are found in state and federal codes. For example, Maryland statutes are found in the Maryland Code Annotated, and federal statutes are found in the U.S. Code Annotated (USCA).
Citizens can influence the statutes that are enacted by electing representatives who they think will vote as they would and by lobbying those representatives for passage of bills about specific issues.

For example, in many states, nurse practitioners’ (NPs’) prescriptive authority is found in a statute. In those states, the legislatures have considered the issue of NP prescribing and have approved it.

**Regulations**

A regulation is law written by a state or federal agency in accordance with a statute. Agencies are a part of the executive branch of government. A regulation cannot directly contradict a statute but may expand on a statute, supplying details not included in it. The divided responsibility—between the legislature to enact statutes and the executive branch agencies to write regulations—is part of the balance of power created by the U.S. Constitution.

Citizens have input into regulations in that regulations, prior to being adopted, usually are published for public review, with an opportunity for public comment. Agencies may or may not accept the comments. Further, citizens who are unhappy with a current regulation can enlist their legislators
to enact laws that require agencies to change the regulations. For example, if state regulations addressing nursing homes do not address NP practice in nursing homes, a state NP organization can ask the director of the appropriate state agency for a change of regulation to include NPs as providers in nursing homes, ask legislators to request a regulation change, and, if necessary, ask legislators for a statute that requires the agency head to change regulations to allow NPs to practice in nursing homes.

**Policies**
Policies are rules made by companies or government agencies that do not have the force of law but that dictate day-to-day decisions. Citizens have input regarding policies only insofar as they can convince whomever has authority over a policy to change it. Citizens may also lobby legislators for a law that requires companies or government agencies to change a policy. For example, a health plan may have a policy of credentialing only physicians. Local NPs who want to be on a plan’s provider panel will want to persuade the appropriate health plan decision maker, through facts, figures, and a presentation of projected benefits to the health plan, of the need to change policy and include NPs on the panel.
The Judicial System
A state court may hold that a state law is unconstitutional, and a federal court may hold that a federal law is unconstitutional. Courts may interpret laws and determine whether laws have been applied as the legislature, or Congress, meant them to be. A citizen who believes that a law has been misapplied and has suffered damage as a result may bring suit in court in an effort to force correct application of a law. For example, in 1983, the medical board in Missouri brought legal action against two NPs practicing in a women’s services clinic, arguing that the NPs were practicing medicine without medical licenses. The lower court agreed that the NPs were practicing medicine without a license. So the NPs took the case to the highest court in Missouri, and after reviewing historical documents, this court held that the intent of the legislature in expanding the nurse practice act had been to expand the scope of practice to include the activities performed by the NPs.

Health Policy
The word policy is defined by the *Merriam-Webster Collegiate Dictionary* as “a definite course or method of action selected . . . to guide and determine present and future decisions.”

Presidents and governors have policies on health
care. Executive branch policies may influence the activities of federal and state agencies. However, unless policy becomes law, it may or may not have any effect on the way people do things.

An example of the influence of policy on the healthcare industry is President Clinton’s 1994 effort at healthcare reform. The president had a definite course of action, a move toward a one-payer system, that is, government-run health care. The president’s plan was not enacted, however. In fact, it was criticized so soundly that it was never even introduced as a bill in Congress. But the threat implied by the Clinton healthcare reform policies—that if the healthcare industry did not change itself, the government would impose changes—encouraged the private sector to reform. Health care today is quite different from health care in 1993. Managed care is now a household phrase. President Obama followed up on President Clinton’s efforts to reform health care, advocating for the Affordable Care Act (ACA), which passed Congress in 2010 and included some aspects of the Clinton plan. To date, however, it is unclear how the provisions of the ACA will ultimately change healthcare policy and/or the industry and practice of health care; as of the publication date of this book, it
It is unclear whether the new federal administration will maintain, change, or repeal the ACA.

**Laws and Rules That Affect NPs**

NPs are affected by laws, regulations, policies, and court decisions that address the following:

- The scope of NP practice
- Reimbursement for health services
- Qualifications for NP licensure and renewal
- Delegation of authority by physicians
- Quality of care
- Requirements for collaboration
- Confidentiality and patient privacy
- Electronic medical records and e-prescribing
- Medical homes
- Compensation for referrals

NPs sometimes find laws, regulations, and policies to be barriers to the practice for which they were educated. How can NPs change these legal barriers?

**Changing Laws**

NPs who seek to change laws generally do so because they find that a statute, regulation, or policy keeps them from doing something necessary for practice. For example, federal law governing payment for home health services does not
authorize NPs to order home care. A physician’s signature is required. NP organizations have had a bill in the U.S. Congress to change that, though, as of the date of publication of this book, that bill has not passed. Another example, at the state level, is when NPs found that they needed to be able to sign death certificates. In several states, legislatures have addressed this issue and state law specifically authorizes NPs to sign death certificates.

**Understanding the Big Picture**
Various forces and interest groups want different things from our healthcare system. Individual patients want prompt, competent, caring attention to their health problems. Payers want to limit costs, increase revenues, and be assured that they are paying for quality care. Clinicians want time to evaluate patients, broad authority to order what they think is necessary, and decent compensation. Professional organizations want to preserve or improve their members’ status. Lawmakers want to satisfy their constituents and be reelected. Bureaucrats want to satisfy their bosses and avoid public criticism. All of these “wants” cannot be satisfied at the same time through health policy.

**What Is Going On?**
Some individuals in this country still do not have access to health care whether because of geographic isolation, a dearth of services, or inability to pay. Those who do have access sometimes complain that they don’t receive enough attention or don’t receive it quickly enough. Medicare and Medicaid are in constant danger of running out of money. Employers complain about the burden of providing health insurance to employees. Insurers raise prices and sometimes cut coverage. Clinicians feel overworked, underpaid, and burdened by what they can and cannot do. Policy makers try to work out systems and policies that resolve all of these complaints. Sometimes, it is a matter of trial and error.

For example, in the late 1990s, capitation was thought to be the answer to America’s healthcare problems. Previously, all healthcare services were fee-for-service, that is, every visit or procedure carried a fee. Managed-care companies attempted to change fee-for-service reimbursement to capitated care, meaning clinicians would be paid a monthly fee for the care of patients enrolled in the practice, no matter how much or little care was provided. For a variety of reasons, capitation has come and gone for the most part, and we are back to fee-for-service reimbursement. However, recent
health policy proposals have offered clinicians a mix of capitation and fee-for-service. For example, Medicare is proposing, as of the publication date of this book, to pay clinicians a set amount per month to attend to preventive care and health maintenance and also pay fee-for-service for illness-related care. In return for the set payments, clinicians would be expected to document their performance on specified quality measures. One can only speculate on whether this plan will satisfy all of the various parties and factions and how long it will take to become functional.

Whatever policies emerge as “keepers,” there is no doubt there will be increased attention to requiring providers and clinicians to document outcomes and quality of care. In the past 20 years, the healthcare industry has come under scrutiny regarding quality of care from the people who purchase the most services—Medicare and the employers who buy health care for employees—and from consumer-oriented groups. Employers are making decisions about which health plan services to offer employees based on quality data gathered by such organizations as the National Committee for Quality Assurance (NCQA). Employers monitor the NCQA data, NCQA monitors health plans, health plans
monitor practices, and often, practices monitor individual providers.

State and national legislators, wanting to ensure that citizens’ best interests are not overshadowed by the goals of employers and insurers to make money, are introducing bills to improve quality and to make sure that citizens get the care they want or need. For example, some state legislatures have passed bills requiring that health plans allow postpartum mothers to stay overnight in the hospital for 24 hours after delivery in response to the practice of health plans requiring mothers to go home shortly after delivery. Citizen groups felt that good care required that postpartum mothers have at least a one-night hospital stay. Thus, legislatures have been delving into healthcare decisions formerly made only by clinicians and lately made by insurers and clinicians.

**Where Do NPs Appear in This Landscape?**

Many commentators have proposed that NPs are the solution to the problems of healthcare access and cost. Here are some media examples:

NPs are likely candidates for the position of primary care provider (PCP), responsible for their own panels of patients. In the past 10 years, NPs have become PCPs and also have become patients’ medical homes. In the 22 states where NPs may practice without a mandate of physician involvement, the barriers to practice have dwindled away. Remaining barriers include the following:

- Reluctance of some commercial payers to credential and directly pay NPs who are not part of a physician practice
- Federal law authorizing only physicians to order home care (which requires an NP in private practice to enlist a physician in order to refer a patient for home health services)
- Federal law requiring a physician to perform the comprehensive assessment for nursing home patients as well as every-other-month evaluations

For NPs in the states with mandated physician collaboration, that barrier remains and requires an NP to engage a physician to be the collaborator or
else forgo practicing. More and more, those who follow health policy find that laws use the words "qualified provider," which includes physicians, NPs, and physician assistants rather than just physicians. It is safe for nurse practitioners to assume that the trend will continue and that barriers will continue to dwindle.

There still are unresolved health policy questions that affect NPs and their employers; for example, many NPs are not taking primary care jobs but are working in acute care, critical care, and medical specialties. Certification as an acute care nurse practitioner is available, but some NPs certified as adult, pediatric, or family NPs are being offered jobs in specialty practices and hospitals. There is no certification available for NPs for most of the medical specialties. So could a newly graduated family NP take a job with a cardiology practice, where in-hospital evaluations of patients are required? Currently, there is little or no health policy on this issue. Boards of nursing make such statements as this one from the Texas Board of Nursing:

> Clinical experience in various settings, continuing nursing education, formal course work and developments in
healthcare all impact individual scope of practice. However, there are finite limits to expansion of scope of practice without completing additional formal education. Advanced practice registered nurses cannot change their legally recognized titles or designations through experience or continuing nursing education; these changes may only be achieved through additional formal educational preparation and meeting all legal requirements to use that title and practice in that specialty set forth by the BON.

The following questions may help to clarify whether a new activity or procedure can be incorporated into an individual’s scope of practice:

- Is it consistent with one’s professional scope of practice?
- Is it consistent with statutory or regulatory laws?
- Is it consistent with one’s education in the role and specialty?
- Is it consistent with the scope of one’s recognized title or does it evolve into another advanced practice title recognized by the board requiring additional formal education and legal recognition?
- Is it consistent with the Standards of Nursing Practice outlined in Board Rule 217.11?
- Is it consistent with evidence-based care?
- Is it consistent with reasonable and prudent practice?
- Are you willing to accept accountability and liability for the activity and outcomes?

This language should discourage a new NP, certified in family practice, from taking on patient care activities traditionally performed by a cardiologist. If a family nurse practitioner (FNP) took a cardiology job with acute care responsibilities and something went wrong, the first thing a plaintiff’s attorney would do is challenge the FNP’s credentials. Given that there is an acute care certification available, an opponent could argue persuasively that the FNP should have obtained that certification before delivering acute care.
Practically, there are not enough NPs certified in acute care to fill the demand, so hospitals and specialty practices have hired FNPs, and so far, there have not been many malpractice cases. Nevertheless, this is one area where NP organizations may want to take a stand and develop a health policy on whether and how NPs can participate in specialty practices and to what extent a family, adult, geriatric, women’s health, or pediatric NP may become involved in acute care.

Present Law
In many states, physician collaboration is a matter of law, although it should be a matter of clinical and professional judgment. Nevertheless, the majority of states still require physician collaboration for NP practice, especially if prescription writing is involved. All states allow NPs to prescribe if they have a collaborative agreement with a physician.

Medicare law still requires that NPs have a collaborative relationship with a physician, though Medicare doesn’t specify the details of that requirement. And each patient admitted to a hospital must have an attending physician of record, even if an NP admits the patient.

Public Perceptions
While research indicates that patients are highly satisfied with the care given by NPs and some patients specifically request NPs as their providers, it is unclear whether there is a general awareness that NPs could be providers in their own right without physician oversight or collaboration. Given the proliferation of convenient care clinics and the increasing utilization of nurse practitioners by medical practices and health systems, it seems likely that the public will continue to learn about and experience the care of NPs and that people who are satisfied with their care will be supportive of any decrease in barriers to NP practice.

What Must Happen for NPs to Be PCPs?
For NPs to achieve full provider status, three things must happen. Laws have to permit NPs to be PCPs and medical homes; the public must accept and be comfortable with the concept of NPs as PCPs and medical homes; and managed-care organizations (MCOs), practices, and hospital systems must agree to designate NPs as PCPs. States that do not define a PCP as an NP will need to be convinced to add this legal permission. Public relations efforts should be aimed at convincing the public that they are safe with NPs. Simultaneously, MCOs need to
be convinced of the advantages of having NPs as PCPs.

Laws can prohibit NPs from practicing, say nothing about NPs, or permit NPs to practice and protect that NP practice. An example of a prohibitive law is “A separate office for the nurse practitioner shall not be established.” This language was enacted in 1995 by the Virginia legislature, but the legislature eliminated it in 2012. An example of a permissive law is “APRNs may serve as primary care providers of record” (Vt. Nursing R. § 15.2[f]).

An example of a protective law (protective of physicians) follows:

It shall be an improper practice for the governing body of a hospital to refuse to act upon an application for staff membership or professional privileges or to deny or withhold from a physician, podiatrist, optometrist, dentist or licensed midwife staff membership or professional privileges in a hospital, or to exclude or expel a physician, podiatrist, optometrist, dentist or licensed midwife from staff membership in a hospital or curtail,
terminate or diminish in any way a physician’s, podiatrist’s, optometrist’s, dentist’s or licensed midwife’s professional privileges in a hospital, without stating the reasons therefor, or if the reasons stated are unrelated to standards of patient care, patient welfare, the objectives of the institution or the character or competency of the applicant. It shall be an improper practice for a governing body of a hospital to refuse to act upon an application or to deny or to withhold staff membership or professional privileges to a podiatrist based solely upon a practitioner’s category of licensure.

*Citation:* N.Y. PUB. HEALTH LAW § 2801-b.1.

NPs need to work to erase the laws that are prohibitive. NPs need more laws that are permissive and protective. An example of a law protective of NPs would be the following:

A managed-care organization may not refuse to act upon an application for
staff membership or professional privileges, or deny privileges for a nurse practitioner, without stating the reasons therefor, or if the reasons stated are unrelated to standards of patient care, patient welfare, the objectives of the institution or the character or competency of the applicant.

This is a slight alteration of New York’s law quoted here, which protects physicians, dentists, podiatrists, optometrists, and nurse midwives from being denied hospital privileges without fair reason.

The first step for state and national NP organizations is to have an attorney analyze the law to identify barriers. Sometimes, when arguing about a professional issue, competitors will cite laws of which NPs were not even aware as the basis for barring NP participation.

The top priority areas where laws need to be changed to reflect NP training and practice are as follows:

- Authorization of PCP status
- Reimbursement
- Hospital privileges
- Eradication of legal requirements for physician collaboration
- Authorization to admit patients to skilled nursing facilities and to provide the required comprehensive evaluation as well as all required routine monthly evaluations
- Authorization to order home health services
- Authorization to serve as medical director for hospice
- Authorization for NP practices to be medical homes

Once prohibitions are erased from the law and permission is certain, NPs will want to work toward legal protection. Other professions, notably physicians, have remarkable professional legal protection. The legal protection of physicians has been so great that the public associated “healthcare provider” with “physician” until recently, when other providers began to be assertive about their roles.

The stage is set for more permission and protection of professions other than physicians. For example, Medicaid law requires an insurer to offer a variety of choices to enrollees. Some state laws require insurers to pay NPs for services.

The Process of Changing the Law
Law change involves certain steps, including these:

- Developing a set of goals and legislative strategies for achieving the goals
- Developing relationships with lawmakers
- Analyzing present state law for barriers to NP practice
- Monitoring law changes proposed by other groups
- Responding to proposed law that affects NPs adversely
- Following up to see how bills that have been introduced have progressed
- Arranging testimony when bills come up for a hearing
- Arranging for communication with legislative representatives
- Drafting and arranging support for legislation that supports the NP agenda
- Following through until the bill is written into regulations
- Debriefing to see how the process can be done better next time

**Developing Goals and Strategies**

Clinicians know what gets in their way. NPs who have considered starting practices or who have actually done so know what stopped them from getting paid, how difficult it can be to get a good
physician collaborator, and whether they need hospital privileges. NP organizations should poll their members to develop a list of goals for the organizations. Then, keeping in mind that law must be in place, public perception must be favorable, and payer policies must be permissive, organizations can develop strategies for overcoming barriers. Strategies might include hiring a lobbyist, drafting a bill, hiring a public relations firm, brainstorming about ideas for news articles on NPs, meeting with researchers about data collection on NP practices, meeting with groups to ask for support, or meeting with MCO executives to explain the benefits to their businesses of having NPs as providers.

Developing Relationships with Lawmakers

NPs who attend fundraisers, assist candidates at election time, or otherwise get to know the lawmakers in their districts find that cooperation is there when it comes time to sponsor and vote for a bill important to NPs. And when NP organizations engage effective lobbyists, the lobbyists, who have devoted years to establishing solid relationships with lawmakers, can be called on to visit legislators and make the NPs’ case for change.
Analyzing Law for Barriers to NP Practice

An attorney familiar with the NP role should analyze the law of each state for each state organization. First, the attorney will analyze the law that names NPs to determine whether any prohibitions exist or permission or protection is needed. The attorney will also look for laws that do not name NPs but that regulate health care in a way that affects NPs. For example, the attorney will analyze state insurance law even if it does not name NPs as reimbursable providers. The attorney can locate the clause that should name NPs as reimbursable providers. The attorney should also analyze state law that addresses healthcare quality. If a law says a physician must oversee all care of patients in MCOs, the attorney can locate the clause that neglects NPs and suggest language changes that will remedy the barrier for NPs.

Monitoring Changes to the Law Proposed by Other Groups

NPs are not the only group looking to change the law. NP organizations need to have someone monitoring proposed statutes and regulations to see how incoming law might affect NPs. That someone most likely will be the NP organization’s lobbying firm. Physicians have historically sought protective
language and will continue to do so, as will physical therapists, physician assistants, chiropractors, and other professionals. It is frustrating enough that NPs must change laws that were enacted before NPs existed. It is doubly frustrating when NPs are caught off guard and a new law is made that excludes NPs.

Collaborating with Other Stakeholders
Sometimes a law is proposed that adversely affects NPs but is not a result of professional competition. Instead, the proposed law is aimed at solving some unrelated problem. For example, the agency that administers Medicare, the Centers for Medicare and Medicaid Services (CMS), sets the rates of payment for visits by Medicare patients. Physicians, NPs, physical therapists, chiropractors, and many other groups may all be working toward the same end: increasing those rates. In such situations, NPs may find allies in other professional groups. Again, to participate, NPs must be aware of the proposed law changes.

Following Up on Bills in Progress
A bill may be changed many times between introduction and passage. The job of the lobbyist includes checking on bill status nearly every day to determine when the hearings are, what
amendments have been proposed, when the votes will be held, who is in favor and who is opposed, and what bills have been introduced that may counteract any given bill. Sometimes an NP organization, to get the legislative support to pass its bill, will need to agree to support another group’s bill. In that case, a lobbyist must know who backs which bills, who will give what support in return for support, and what the NP organization’s parameters are in terms of what can be supported and what cannot.

Arranging Testimony
Legislative committees hear testimony on a bill before a vote is taken to pass the bill out of committee and to the full legislative body, house, or senate. At hearings, citizens are permitted to address the committee or legislative body about the effect a bill will have on a citizen or group. Committee members may question those who testify. Often, there are many people who want to testify on a particular bill. There may be several hearings in a day. Keeping in mind that legislators can digest only so much information, parties are advised to keep testimony short and to the point. Three minutes is often all an individual has to make his or her point.
Legislators will be more affected by testimony that a bill will affect many people or will affect some people greatly. For example, a legislator is likely to be more swayed by testimony that a particular bill will open health care to 17,000 uninsured citizens than by testimony that a bill will give reimbursement to five self-employed NPs. On the other hand, if an NP can show legislators how the number of self-employed NPs could, with release of barriers, soon grow to 2,500 self-employed NPs who can participate in a state program for the uninsured by offering reduced-rate services, legislators’ interest is likely to be stimulated. Legislators, like the population in general, are moved by issues that affect mothers and children, the elderly, public safety, and public expenditures. Testimony that shows how a bill touches on these issues can be very effective.

Lobbyists often help NP organizations develop testimony and testifiers. If a bill affecting NPs also affects patients, it is often helpful to have patients testify on behalf of the bill.

Arranging for Communication with Legislative Representatives
Citizens can communicate their opinions to legislators through telephone calls, emails, and visits as well as in hearings. Legislators make
themselves available to citizens at such gatherings as “nurses’ night at the legislature” and other receptions. All legislators have aides who can hear citizen concerns and pass those concerns along to the legislator. NPs who want to communicate with legislators about professional issues can arrange for a personal visit with their individual legislators in their districts, telephone the legislator or aide, ask patients to contact their legislators about an NP issue of interest to the patient, and/or hire a lobbyist to communicate with the legislators.

It is a fact of life that legislators need money to conduct reelection campaigns. Legislators do, in fact, take the time to listen to contributors. Legislators remember the individuals and groups that contribute to their campaigns. Many NP organizations have political action committee funds that they use to support legislative campaigns. This is an important use of association funds.

Drafting and Arranging Support for Legislation That Furthers the NP Agenda
The drafting of legislative language is an art. Lobbyists, legislators, and attorneys do it. Citizens and associations do not do it, or rather, they usually do not do it well. A bill has to take into account the
existing law, the form that state law takes, possible unintended consequences of particular language, the state-defined meaning of particular words, the possible reaction to opponents and competitors to specific language, and the need for conciseness and clarity of expression.

NP associations usually begin a bill-drafting process by discussing the problem NPs are trying to solve with a lobbyist. The lobbyist then locates the section of law that needs to be changed and proceeds to draft language changes that will solve the problem. Lobbyists, when drafting bills for NPs, often will get opinions from selected legislators and other professional groups about possible language in an attempt to pretest reactions to specific language. Often, the time between when a bill is conceptualized and it is introduced, the bill’s language has been changed and rearranged many times. And after the bill is introduced, the language may be changed several times through amendments.

After there is a draft of language for a proposed bill or during the drafting process, a lobbyist seeks sponsors. A bill’s sponsor introduces it and shepherds it through the legislature. There can be companion bills in both houses of the legislature, in
which case there should be a sponsoring senator and a sponsoring representative. The selection of a sponsor is crucial because his or her personality, committee position, affiliations, and popularity will affect how the bill progresses; for example, a well-positioned sponsor may decline because the legislator is trying to curry favor from an opposing group. It is not uncommon to “shop” for sponsors.

After a lobbyist gets a bill sponsor, the search is on for cosponsors. A bill with many cosponsors is likely to get passed. No legislator likes his or her name on a bill that fails. So cosponsors can be expected not only to support the bills they cosponsor but also to work for passage of those bills.

After obtaining sponsors and cosponsors, a lobbyist’s next task is to line up testimony for committee hearings. Then, after a hearing, a lobbyist turns his or her attention to locking in votes. Lobbyists ask legislators directly whether they intend to vote for or against a bill. If the vote is no, a lobbyist can ask why. If something about the bill can be tweaked to change a no vote to a yes, a lobbyist can draft an amendment and seek the approval of sponsors, cosponsors, and other favorable voters on the amended language.
Finally, the bill comes to a vote. It must pass each house of the legislature. A bill that passes both houses then goes to the governor for approval. The final hurdle is escaping a gubernatorial veto. Lobbying is done even at this final stage to convince the governor and his or her staff of the worth of the bill.

After a bill becomes a law, the bill is codified, that is, written into the state’s code of laws. Many bills are further expanded on in regulations written by the state agencies that carry out the laws. Regulations may include detail not specified in the law, but regulations cannot directly contradict a statute.

NPs who are working toward legal change will want to work closely with their lobbyists all the way through regulation writing. After it is over, they can debrief to see how things could be done better next time.

**Hiring Lobbyists and Attorneys**

Lobbyists and attorneys often serve many clients and may or may not know the issues that are most important to NPs. An NP association that is fortunate enough to have a lobbyist and an attorney who are well versed in NP issues and already familiar with the law regarding NPs has a head start.
When interviewing an attorney or lobbyist, ask these questions:

- What is your experience with NP issues?
- Have you personally experienced the care of an NP?
- Who are your other clients? Might their issues conflict with NP issues?
- Do you have any opinions about NPs?
- What does an NP do?

One would think a lobbyist or attorney who has scheduled an interview with an NP organization would have done enough research to answer this last question. But surprisingly, that is not always the case. A prospective lobbyist or attorney who cannot answer this question should not be hired.

**Do-It-Yourself Lobbying**

Some NPs are very good at testifying. Usually, the best testifiers are those who have had the most practice. When called to testify, ask who the committee members are and whether any are healthcare providers. Ask about a time limit. Ask who else will be testifying, and coordinate the testimony if possible. The best testimony has an introduction, a middle, and a conclusion, just like a good story. Storytelling is the way to persuade
legislators. Polish is not a necessity, but it helps; certainly preparation is essential.

**Should NPs Join with the State Nurses’ Association for Lobbying?**

In some states, the NP association is a separate organization from the state nurses’ association. In other states, NPs are an interest group within the state nurses’ association. Ideally, from the point of view of an outsider, the state nurses’ association would take care of legislative issues for all nurses. However, NPs sometimes find that their issues are a lower priority for the state nurses’ association than they would like. NPs have sometimes formed their own organizations and hired their own lobbyists for this reason.

It is worth noting that in some states where state law is quite favorable to NPs, lobbying has always been done by a strong state nurses’ association, of which NPs are an interest group. Officers of NP associations should attempt to work with the state nurses’ association on legislative issues. If after attempting to work with the state nurses’ association, NPs find they cannot get what they need, then NPs can hire their own lobbyist.
Dealing with Government Agencies

Many people who work for government agencies lack an understanding of health care and specifically the role of NPs. Though an NP might expect that a state or federal agency would research an issue when knowledge is lacking, many state agencies rely on citizens and their representatives to bring problems to light and to do the legal research to support the proponent’s position. When NPs or their hired representatives become familiar with the personnel of state and federal agencies and seek person-to-person communication about an NP issue, questions and problems can often be taken care of efficiently at the agency level without resorting to legislative action. Further, NPs will be included in government policy making when they sit on the advisory panels and commissions making the policies. It is part of a lobbyist’s job to know the influential policy-making commissions in a state and attempt to get NPs appointed to these commissions and boards.

The Competition

Change would be easy if there were no competition. There is competition, however, and it is useful to know where it comes from and what competitors’ interests are.
Physician Competition
Physicians fought hard for their position in health care and now fight to maintain it. The fight is by no means limited to NPs. Physicians have fought against other providers, such as homeopathic physicians and optometrists, and now they sometimes fight against hospitals, health plans, and MCOs, which physicians perceive as threatening physician autonomy.

Through capturing the mechanisms of reimbursement, physicians were able to secure and maintain a dominant position among healthcare providers. They are not going to give up their position now.

NPs made significant progress in erasing barriers to practice in the 1970s because of a physician shortage in certain areas. NPs made some progress in the 1990s because of a funds shortage. Now, NPs are making progress because of need for access to care. There still are many legal and policy barriers to NPs, many of which were established by and are now maintained through physician influence. In recent years the NP has been increasingly viewed by some physicians as a competitor, and this view is unlikely to change.
Competition is something NPs always will need to budget for in terms of time, energy, and money.

**Competition from Physician Assistants**
Physician assistants (PAs) have many of the same goals as NPs: professional recognition and respect, the ability to make a good living, and the ability to control one’s work product. PAs will have to fight their own battles because their profession was set up differently from the way NPs’ profession was set up. However, there is significant opportunity for NPs and PAs to work together to advocate for their professional interests. While individual NPs may compete with individual PAs for specific jobs, it is not fruitful for NP professional organizations to engage PA organizations in competition in the public arena.

**Competition from Other Nurses**
Some NP associations find that when they go for inclusion in the law as providers, other nurses want to be included as well. At that point, there is a possibility that the legislature will be hearing competitive arguments from NP and other nursing groups about the relative merits of each group. As with PAs, NPs and nurses have many of the same goals. It will not serve either group well to fight, and public fighting will definitely cause harm. Peaceful
coexistence is the key. If NPs put forth only efforts to further their profession and do not engage in efforts to hold back other professions, not only will time and expenses be saved, but public relations will be better.

How Can Individual NPs Make a Difference?
Individuals can influence lawmakers and lawmaking in the following ways:

- Ask candidates in local elections about their position on NPs, and vote accordingly. Support good candidates with campaign contributions, noting on the check that you are an NP.
- When a bill concerns NPs or health issues of concern to NPs, call or write legislators, noting that you are an NP.
- When regulations are proposed that affect NPs, write and send comments on how the proposed regulations will affect NPs.
- Join an NP association.
- Write letters to the editor of the local newspaper about news events affecting NPs or your patients.

Conclusion
The process for making law conform to NP goals for the profession is this:
1. Analyze the current law for prohibitions and lack of permission and protection where it matters. Have an attorney, policy analyst, or lobbyist work with the NP organization to do the analysis.

2. Draft a bill that erases prohibition, gives permission, or affords protection for NP practice. Have an attorney, lobbyist, or legislator work with the organization to do this.

3. Gather support for the bill among lawmakers and the public. Enlist the participation of association members in each legislative district.

4. Introduce the bill, and follow its progress, testifying, educating lawmakers, and arranging give-and-take with other groups when necessary. At this stage, professional lobbyists should be running the show.

5. Follow the bill through to the regulation-writing stage, monitoring the language of proposed regulations and commenting on the proposed regulations through letters. Have an attorney do this.

6. Refine the approach, based on what was learned with previous law changes. Association officers, attorneys, and lobbyists should do this.
Notes


Chapter 13: Promoting the Profession to the Public

According to studies of patient satisfaction, most patients who have seen nurse practitioners (NPs) like them, but not everyone has seen an NP. People who are healthy and rarely visit any healthcare provider may not have experienced care given by an NP. Those who have had a long relationship with a physician also may not have experienced NP care.

NPs have had little, if any, exposure in popular culture. For example, there are no equivalents of the Grey’s Anatomy primetime television doctors for the NP profession. These TV characters, doing their work on the air week after week, have given the average viewer the sense that they know what physicians do.

There are no well-known figures in literature who are NPs. Most children do not grow up reading books about NPs. There are no well-known NP dolls or action figures. There are no NPs who are U.S.
senators or congressional representatives, though NPs now are serving in state legislatures.

Furthermore, no advertising campaigns keep NPs in the public eye (in the way that, for example, advertising keeps Coca-Cola at center stage). In contrast, however, the American Medical Association budgets millions for major public relations (PR) efforts.

All of this may change in the near future, because NP organizations and NP business owners now understand the necessity of organized PR plans to promote the profession and its agenda. NPs who want to see the passage of legislation favorable to their practice and NPs who have their own practices and want to see them thrive will want the public to have an opinion about NPs, and they will want that opinion to be favorable. NPs have made great progress on a one-on-one basis. In fact, the main way the public currently comes to understand what NPs do is by experiencing their care.

Those who have not experienced the care of an NP can be encouraged, through PR efforts, to seek the care of an NP. In the past several years, many practices have generated newspaper articles when a new NP joins the practice. Some NP organizations
have supported media campaigns. Some NPs and most NP organizations have a social media presence—websites, blogs, Facebook pages, and Twitter accounts, for example.

**Public Relations Steps**
There are systematic ways of raising public awareness about NPs. Marketing, PR, and sales all have the same process:

1. Develop a message.
2. Determine whom the message should reach. This includes both potential patients and "influencers"—those who are persuasive and might convince others in their network to contact an NP.
3. Determine the best way to disseminate the message.
4. Disseminate the message.
5. Evaluate the success of the effort and fine-tune the process.

The specific steps in a PR strategy for NPs are as follows:

1. Set a goal.
2. Develop a plan.
3. Develop a budget.
4. Work the plan.

**Setting the Goal**
A likely PR goal for NP professional organizations is to establish NPs as experts on primary care. An alternative goal for an individual NP with a private practice may be getting patients to come in the door.

There is also a place for specialist NPs. Several NPs have taken on pediatric enuresis as a specialty, for example. Others have taken on nonsurgical treatment of incontinence in women. These NPs have the goal of establishing themselves as experts for patients with specific problems. One NP, Reeger Cortell of Medford, Oregon, focuses on educating individuals who are contemplating or have had bariatric surgery. She has a podcast with a significant following, over 100,000 downloads. In one of her podcasts, Ms. Cortell said she initially was reluctant to call herself an expert even though she had spent several years studying and teaching the subject. However, it is clear to anyone who listens to her podcasts that she is an expert.

**Developing the Plan**
Whatever goal is selected, the plan will revolve around establishing NPs in general, or individual
NPs, as high-quality professionals. The most effective forms of publicity show the expertise of NPs in a way the public can understand. NPs can convey expertise in a number of ways:

- By providing high-quality care to each patient, on a one-on-one basis
- By word of mouth, such as when a friend or family member has a good experience of care and shares it
- By including testimonials from patients in brochures, promotional videos, or paid advertising
- By arranging for articles written by NPs on health topics to appear in local newspapers or on popular blogs or websites
- By arranging for radio or television talk show appearances by NPs
- By speaking on healthcare topics at community forums
  - By podcasting
  - By posting video blogs on medical or nursing topics
- By blogging
  - By participating in webinars
  - By having a presence on a social media platform
- By serving on healthcare advisory boards in the area and nationally
- By endorsing, as an association, particular sets of preventive care guidelines and standards

A simple PR plan that focuses on a series of news releases is described in Appendix 13-A. Tips for using social media platforms are provided in Appendix 13-B.

**Developing the Budget**

PR can be done with a million-dollar budget or a hundred-dollar budget. Either way, there must be a budget, time-wise and finance-wise, or nothing will happen. The majority of a PR budget will go toward services. It costs money and takes significant time to produce and host a podcast, webinar, video, or blog. The researching and writing of news releases, communication with reporters, and follow-up via telephone calls will cost money, unless one already is an expert at public relations. Advertisements in magazines and newspapers are expensive. It pays to shop around among the various media. One year, a state NP organization spent its PR money on a billboard on one of the major highways in Georgia.

Even a small NP organization should count on spending about $15,000 a year on PR. Besides membership dues, this money can be generated
from other business ventures. One job of a PR professional, for example, can be to promote an NP educational conference with a registration fee. Such an event would presumably turn a profit. Another job of a PR professional is to develop written materials—brochures and fact sheets on NPs—that can be sold to individual NPs and practices and distributed to patients.

**Working the Plan**

**Proactive PR**

In a proactive PR plan, an NP organization seeks to generate articles or television pieces about NPs or to showcase the expertise of NPs not in response to attacks or in defense of NPs but rather as a regular, systematic promotion strategy. For example, an NP organization might arrange for an article to appear in the local newspaper giving an NP’s advice for staying well during the flu season. The article serves three purposes: (1) it keeps NPs in the news in a positive light, (2) demonstrates the information an NP can offer, and (3) gives people useful information. In addition to satisfying the needs of NPs and patients, such an article satisfies the needs of newspaper editors to run informative articles.

A message about NP expertise in primary care can be disseminated on television; in newspapers and
magazines; at health fairs; by word of mouth; and through advertising, websites and blogs, and email. It is generally agreed that television stories, newspaper articles, websites, and emails are effective ways of getting a message to a large segment of the population with little expenditure.

When developing a PR plan, NPs need to keep in mind that newspapers, television station owners, and websites need readers (or viewers) and advertisers. An NP organization may not be able to offer advertisers to a newspaper, but it can offer readers, particularly if a contributing NP is providing information on a topic of interest to many people. Health, and particularly primary care, is interesting to many people.

To generate an article in a newspaper or on a website, the following things have to happen:

1. Generate an idea for an article.
2. Generate the information to be conveyed.
3. Write the news release.
4. Identify the appropriate vehicle for the article.
5. Identify the decision maker (editor) who can ensure that the article will get into the paper or on the website.
6. Give the editor the name of a contact if the editor wants more information.
7. After the release has been sent to the editor, follow up by telephone call or email.
8. Arrange for more information to be given to the editor, or arrange for accompanying photographs or art.

A statewide media campaign might, for example, involve sending a news release to every newspaper in the state once a month. When the process just described is undertaken 12 times a year and multiplied by 50 or 100 newspapers, it is close to a full-time job.

Each NP organization and private practice needs a person designated to handle PR. PR services may be purchased or performed by a volunteer NP. An NP volunteer is less expensive and likely to know more about NPs than a PR professional and will be highly motivated. However, an NP volunteer probably has a full-time job, and as a result the volunteer PR efforts may not get the regular attention they need. Further, when NPs organize into associations and there is a treasury, it makes sense for all NPs to share in contributing to PR efforts, and that is best done by purchasing PR
services rather than imposing on one NP to do the work.

**Reactive PR**
PR is reactive when it is in response to a particular event or criticism. For example, if a physicians’ group came out with a statement that all NPs should practice only in a collaborative or supervisory relationship with a physician, the rebuttal of an NP organization would be reactive.

The keys to effective reactive PR are speed and a consistent and logical message. Therefore, NP organizations should have a set of talking points ready for use in the event that such a timely reaction is needed. Talking points are a PR method for ensuring that a spokesperson for a group has something to say and that his or her message is consistent with the group’s goals. For examples of talking points for NP organizations, see Appendix 13-C. An organization also needs to have a set of email addresses for media outlets ready, for use when a response to an event or criticism is called for.

**The Substance of the Message**
When NPs are asked how they differ from physicians and why they should be authorized to
practice without mandated physician collaboration, they must be ready to support their answer with hard facts and data.

Compare the following two statements: “NPs are good listeners and safe and effective providers of health care” and “A health services research team studying 799 episodes of otitis media and sore throat in a Columbia, Maryland, HMO found that NPs were more effective at resolving the problem. And NPs’ care was 20% less expensive than MDs’.” Which statement will more effectively persuade businesspeople and lawmakers that NPs are value-added providers? The second statement is what an NP should tell an insurance executive, an employer, a reporter, or a congressperson. NPs know that the first statement is true, but to convince others, they must have hard facts and numbers.

Supporting Data
Here is an excerpt from a health policy brief titled “Nurse Practitioners and Primary Care,” published in Health Affairs:¹

Studies comparing the quality of care provided by physicians and nurse practitioners have found that clinical outcomes are similar. For example, a
systematic review of 26 studies published since 2000 found that health status, treatment practices, and prescribing behavior were consistent between nurse practitioners and physicians. What’s more, patients seeing nurse practitioners were also found to have higher levels of satisfaction with their care. Studies found that nurse practitioners do better than physicians on measures related to patient follow up; time spent in consultations; and provision of screening, assessment, and counseling services. The patient-centered nature of nurse practitioner training, which often includes care coordination and sensitivity to the impact on health of social and cultural factors, such as environment and family situation, makes nurse practitioners particularly well prepared for and interested in providing primary care.

Recent studies (and not so recent studies) have found NPs to be as good as or better than MDs as primary care physicians (PCPs). These studies
should be on the tip of anyone’s tongue who is trying to sell the concept of the NP as the preferred healthcare provider.  

**Study 1: NPs Match MDs on Primary Care Tasks**

Hall et al. set up audit criteria, with input from the practitioners being studied, and then audited charts of 426 MDs and NPs (total) in 16 ambulatory care practices. The researchers looked at eight tasks:

1. Following up on a low hematocrit to detect patients with anemia caused by colorectal cancer or other serious gastrointestinal disease
2. Screening for cancer using breast examination and Pap smears in women
3. Following up on a high serum glucose to detect and treat diabetes
4. Monitoring patients on digoxin to detect drug toxicity or symptomatic relapse
5. Following up on a positive urine culture to treat persistent bacteriuria
6. Complying with the American Academy of Pediatrics standards for screening and immunization of infants
7. Assessing the risk of dehydration in children at the start of an episode of gastroenteritis
8. Monitoring and following up children with otitis media to detect and treat failure to resolve middle-ear effusion

The findings were that NPs’ performance was comparable or superior on seven of the eight tasks. Female MDs were better at cancer screening for women, but male MDs were worse at this than NPs. The sample of male nonphysicians was too small to make any generalizations and was therefore excluded from the results.

**Study 2: NPs Are Cost-Effective**
Salkever et al. compared NPs and MDs on cost and effectiveness. To study costs, Salkever paid observers to time NP and MD visits with patients. The research team then analyzed costs of office space, follow-up visits, ancillary services, and drugs ordered by the providers. To study effectiveness, the researchers randomly surveyed patients regarding problem severity and changes in problem status after treatment. The researchers then computed the cost per episode of care for two conditions, sore throat and otitis media.

The findings were that NPs were 20% less costly in their care. NPs were at least as effective as MDs at resolving the problem.
Study 3: NPs Get to the Root of the Problem

Avorn et al. asked 799 MDs and NPs (total) to consider the following case vignette and answer two questions: 6

A man you have never seen before comes to your office seeking help for intermittent sharp epigastric pains that are relieved by meals but are worse on an empty stomach. The patient has just moved from out of state and brings along a report of an endoscopy performed a month ago showing diffuse gastritis of moderate severity but no ulcer. Is there a particular therapy you would choose at this point, or would you need additional information? What more do you want to know? What would you do?

The findings were that nurses were far more likely to collect more historical information about the patient before deciding on therapy. The NPs asked an average of 2.6 questions about the patient as opposed to 1.6 for physicians. A third of physicians (and 19% of NPs) chose to initiate therapy without any additional information. Nurses were far more
likely to ask about the patient’s diet and psychosocial information (but less likely to ask about alcohol intake). NPs were more likely to suggest nonprescription approaches to therapy, such as a change in diet or counseling to help the patient deal with stress. NPs were far less likely than physicians (20% versus 63%) to recommend a prescription drug.7 NPs were much less likely to state that a prescription drug would be the single most effective therapeutic intervention for this patient (12% versus 46%).8

No analysis of the cost of therapy was done. However, when the cost of the MDs’ treatment plan (prescription medication but no counseling about unhealthy lifestyle) was compared to the NPs’ treatment plan (no prescription but counseling regarding aggravating factors), the NPs’ treatment plan certainly showed itself to be the more economical approach to care.

**Study 4: Patients Are Satisfied with NPs**

*Medical Economics*, a magazine for physicians, conducted a survey of patient satisfaction with NPs and MDs.9 The magazine found that patients were as satisfied with NPs as with physicians.
Study 5: Patients Are Satisfied with NPs
Harrocks et al. systematically reviewed randomized controlled trials and prospective observational studies and found that patients were more satisfied with care by an NP, there were no differences in the health status of patients treated by NPs versus medical doctors, and the quality of care was in some ways better for NP consultations.\textsuperscript{10}

Study 6: NPs Are More Successful at Lowering Patients’ Blood Pressure
Mundinger et al. conducted a randomized trial comparing outcome measures for care provided by NPs and medical doctors. Among other things, they found a statistically significant difference in the diastolic value of patients treated for hypertension by NPs. NPs’ patients had a lower diastolic blood pressure after treatment than physicians’ patients.\textsuperscript{11}

Study 7: Care by NPs Decreased the Risk of Preventable Readmissions
Kuo et al. analyzed potentially preventable hospitalizations of Medicare beneficiaries with a diagnosis of diabetes who were treated by NPs and MDs. Several statistical methods demonstrated that
receipt of care from NPs decreased the risk of potentially preventable hospitalizations. Their findings suggest that NPs are exceptionally effective at treating diabetic patients.\textsuperscript{12}

**Further Data on the Value of NP Practice**
A survey study ($N = 3,257$) comparing OB-GYN practices that used nonphysician providers to physician-only practices found that patients preferred the collaborative practices.\textsuperscript{13} Of the nonphysician providers, 45\% were NPs, 19\% were midwives, 16\% were physician assistants, and 9\% were clinical nurse specialists. Reasons for preferring practices with nonphysician providers were as follows:

- The patient got an appointment in less time.
- More time was spent with the provider.
- More health information was given.
- More diet information was given.

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<tr>
<th>EXHIBIT 13-1 Effective Arguments for NPs</th>
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<tbody>
<tr>
<td><strong>Argument 1:</strong></td>
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<tr>
<td><strong>Data:</strong></td>
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<table>
<thead>
<tr>
<th>Argument 2:</th>
<th>Patients are highly satisfied with NPs.</th>
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<tbody>
<tr>
<td>Data:</td>
<td>Perry and Harrocks studies (see notes 9 and 10)</td>
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<tr>
<td>Argument 3:</td>
<td>NPs have been proven cost-effective in their evaluations and treatments.</td>
</tr>
<tr>
<td>Data:</td>
<td>Salkever and Avorn studies (see notes 4 and 6)</td>
</tr>
<tr>
<td>Argument 4:</td>
<td>NPs give high-quality primary care.</td>
</tr>
<tr>
<td>Data:</td>
<td>Hall, Salkever, Avorn, and Mundinger studies (see notes 3, 4, 6, and 11)</td>
</tr>
<tr>
<td>Argument 5:</td>
<td>NPs emphasize disease prevention and healthcare maintenance.</td>
</tr>
<tr>
<td>Data:</td>
<td>Hall and Avorn studies (see notes 3 and 5)</td>
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Patients felt that nonphysicians were less rushed in their care. However, patients believed that physicians provided more complete information.

For a quick reference to substantive arguments supporting NP practice and citations for the arguments, see **Exhibit 13-1**.
Other Studies Documenting Quality of Care Provided by NPs
NP vs. Physician Outcomes in Patients Treated by Either Provider


Registry. *Journal of the American College of Cardiology, 66*(16), 1803–1812.


**Acute Care**


Geriatric


**Pediatrics**


**Primary Care**


**Collecting Impressive Facts**

Not all hard facts and data come from research studies. Under Medicare’s Physician Quality Reporting System and Merit-Based Incentive Payment System (the latter proposed for implementation after 2017) clinicians report their performance on selected measures. The practice periodically receives cumulative data on these performance measures and may receive additional reimbursement for meeting specified thresholds. When a practice gets a contract as a provider with a managed-care organization (MCO), the practice is likely to receive quarterly performance reports from the organization. The reports compare the practice to the aggregate (average practice) on such qualities as the number of emergency department visits by covered patients, the number of admissions, the length of stay of admitted patients, and the monthly cost of care per patient.

NPs who have their own practices can use Medicare’s data for marketing. NP-only practices still are fairly rare, so it is difficult to find aggregate
data on such practices. NPs who do not have their own practices but who work as employees of MDs or HMOs may find that practice managers are collecting data to compare NPs’ performance with that of local MDs. NPs who collect such data and pool it with other NPs will have substantive answers to such questions from businesspeople and legislators as “Why should we want NPs?”

Not-So-Impressive Facts About NPs
While some of the problems NPs experience with regard to acceptance are brought on by physicians who are guarding their professional territory or by the response of the public to physicians’ successful and persistent PR, some NP PR problems are based on fact. The argument put forth by physician organizations that the education required for entry into NP practice is less than the education required for physician entry into practice is true. The Washington Post gave the following advice to NPs in an editorial.¹⁴

If nurses’ role is to go on changing as quickly as it has, it will be up to nursing schools to look closely at that training—as some clearly have done—and make sure it corresponds to
reality. It remains true that nurses receive far less medical training than doctors (typically two years or less) and a far lower proportion have been to college.

Dealing with the Downside
NPs need to be able to respond positively to comparisons between NP and MD educational paths. There are two ways of dealing with this problem. The first is upgrading the entry into practice requirement to a master’s degree. Forty states already have done this.

Even when a master’s degree is required for entry into practice, NP education will be of shorter duration than physician education. However, no data exist to support the necessity of 4 years of medical school and 3 years of residency to perform primary care. Physicians set those educational requirements without research to support that level of education. The data showing that NPs are excellent PCPs support an argument that master’s-level preparation is appropriate education for PCPs.

In 2004, an association of colleges of nursing recommended that the entry-level degree for new NPs be a clinical doctorate as of 2015. This
recommendation has not been adopted by any state legislature and was simply a recommendation, and most NPs may not feel the need for a doctorate. However, as more NPs get their clinical doctorates, it will become increasingly difficult for organized medicine to point out the differences in time spent on education. However, organized medicine still may point out the differences in content between a medical doctorate and a nursing doctorate.

NP organizations should consider spending some of their budget on PR services to deal with this issue. While organized medicine continues to point out the difference in years spent in education and training, data continue to show that NPs are competent healthcare providers. Among the projects for a PR professional hired by an NP organization is generating publicity, particularly through news releases that establish NPs as experts. Another project is to generate a fact sheet or brochure on NPs, for publication online and on paper, to give out to anyone who expresses interest in and has questions about NPs. See Appendix 13-D for an example of the information that could be included in a fact sheet on NPs.

Finally, each NP organization should designate an NP in the organization who will be the spokesperson
when a reactive comment is needed. This NP should be familiar with the organization’s talking points and unafraid of talking with the news media.

Notes

2. The Salkever study was done by two public health PhDs, an MSW, and an MD. The Hall study was done by four PhDs, an MB, and an MA, from departments of psychology, health policy, biostatistics, and information technology. The Avorn study was done by MDs.


5. For otitis media, the NP cost per episode was $14.98; the MD cost was $18.22. For sore throat, the NP cost per episode was $11.80; the MD cost was $15.64.

7. A month’s supply of both ranitidine and Tagamet (cimetidine) cost close to $100.

8. There was no relationship between nurses having prescription authority in their state and their reliance on prescription versus nonprescription therapy.


Appendix 13-A: A Simple PR Plan for a State NP Organization

This plan can work for a state organization or for an individual NP. It is a simple plan, using newspapers only. Much more elaborate plans can be made with the aid of a good PR expert. More elaborate plans might explore websites, television news coverage and features, primetime shows featuring NPs, public television pieces on NPs, national magazine pieces, radio talk show appearances, speaking engagements, and/or advertising.

For each of the topics that follow, four things need to happen:

1. Develop the substance of the news release. Two or more NPs should be able to do this in less than 30 minutes.
2. Write the news release in the form that news editors are used to seeing. Have a PR professional do this.
3. Place the release. Decide which newspapers and to whom at the newspapers to send it,
and then send it. A PR professional should do this.

4. Arrange for follow-up. Have a contact name on the release. The contact should place a follow-up telephone call if there is no response in 2 weeks. The contact should deal with any responses that come in by helping to arrange interviews and photos and answering questions.

**January**
It is a new year. Place an article with NP advice on annual health maintenance. Suggestions include the time to schedule a mammogram, Pap smear, and yearly cholesterol check.

**February**
It is flu season. Place an article with NP advice titled “The Five Best Ways to Avoid Passing the Flu.”

**March**
It is spring break time. Place an article with NP advice on avoiding ruining spring break, covering points such as wearing seat belts, consuming alcohol only in moderation, and not skiing alone.

**April**
It is pollen season. Place an article with NP advice for allergy sufferers.

**May**
It is prom season. Place an article with NP advice on avoiding the consequences of unprotected sex or drinking while driving.

**June**
It is sunbathing season. Place an article with NP advice on protection of skin.

**July**
It is poison ivy season. Place an article with NP advice on treating and avoiding poison ivy.

**August**
It is hot. Place an article with NP advice on avoiding dehydration and overheating, especially for individuals with medical problems.

**September**
It is back-to-school time. Place an article with NP advice on up-to-date immunizations.

**October**
It is Halloween. Place an article with NP advice for parents on how to oversee safe trick-or-treating.
November
It is Thanksgiving. Place an article with NP advice on the benefits of moderate diet and exercise.

December
It is holiday season. Place an article with NP advice on how to recognize depression and discuss current treatments.
Appendix 13-B: Tips for Promoting a Practice or an Individual NP’s Expertise on Social Media

1. Make claims about your outcomes and/or performance only if you can back up the claim with data or evidence.

2. Never use a patient’s name on a website or social media, and never provide enough information about a patient that someone could figure out to whom you are referring. Technically, you could use a patient’s name if you have the patient’s written consent. However, using patients’ names may give prospective patients the impression that their information will not be kept confidential.

3. If a website or social media platform has an interactive component, make sure that no reader or listener can learn about other participants’ medical issues. All discussions should be general and not related to individual patients.

4. Include a disclaimer on the website that states that information provided on the site is
for general education and should not be used by patients to diagnose or treat their own problems. State that any patient with signs or symptoms should seek an evaluation from a qualified provider. State that the information provided does not create a duty of care and that individuals who want to become a patient or who are enrolled patients and want to address a problem or question should make an appointment for a face-to-face visit.

5. If the site allows for comments, discussion, or some other form of response, check the platform every day to monitor comments or responses.

6. Testimonials are good, but the patient’s name should not be used.

7. Five-star ratings on sites where individuals can rate their healthcare providers are great. But not all individuals who seek care will be satisfied, and sometimes patients will give poor ratings or make comments that may dissuade a reader from visiting the practice. The reason for a poor rating or dissatisfied comment actually may be because of an NP’s making a correct decision but not the decision the individual wanted. For example, an NP may decline to provide a prescription for a controlled drug to a patient who wants it but
doesn’t need it. The disappointed individual may choose to grade the NP poorly, even though the poor grade is not deserved. Clinicians have no control over the sites that allow patients to grade providers. It is wise for clinicians and practices to look at their ratings from time to time, analyze both positive and negative ratings, make changes where necessary, and if the site allows, respond to comments.

8. Do not use photos of patients. Technically, a practice could use a photo of a patient with the patient’s consent or a child’s with the parents’ consent. However, use of patient photos, even with consent, may convey a message to viewers that confidentiality might not be a priority.
Appendix 13-C: Some Talking Points for NPs

1. Every study of NP cost-effectiveness has shown that NPs are cost-effective primary care providers.

2. Every study of NP quality of care has shown that NPs provide effective and safe care.

3. Every study of patient satisfaction with NPs has shown that patients are very satisfied with them.

4. Research has been corroborated, no matter whether the researchers were nurses or physicians.

5. Some MDs still are fighting NP admission to provider panels because of the pressures of economic competition.

6. The American Medical Association surveyed physicians who employ NPs and found that the physicians think NPs operate with a high level of autonomy. In practice, physicians who hire NPs do not supervise NPs but rather provide consultation when the NPs request it. Only when it is suggested that the flow of
money go straight to the NP do physicians begin to protest.

7. NPs want to collaborate in the provision of health care. Collaboration is necessary for quality care. However, mandated collaboration is not necessary and may restrict patient access to care.

8. Experts agree that NPs are the way to go.

9. Unless NPs are admitted to provider panels and credentialed with payers, there will be no real-world data on NP costs, effectiveness, attention to preventive measures, outcomes, or utilization. That research cannot be done unless NPs have a panel of patients and their practice patterns are tracked, as is done with physicians.

10. Patients deserve to have a choice of NP as provider. Let the customers decide what kind of healthcare provider they want.

11. Take the reins for controlling NPs out of the hands of physicians. Physicians have an economic conflict of interest.

12. Put the reins for controlling the quality of the NP profession in the same hands that control quality over other healthcare providers:
   a. Licensing boards
   b. Consumer-oriented groups (such as the National Committee for Quality
Assurance and The Joint Commission)
c. The MCO credentialing process
d. MCO audits
e. Health Employer Data and Information Set (HEDIS) report cards
f. Medicare’s Physician Quality Reporting System (PQRS) or Merit-Based Incentive Payment System (MIPS)

13. NPs provide a perfect fit of provider and patient need.
14. There is still a shortage of PCPs in the Northeast [fill in your region].

Counterarguments to Medical Society Talking Points
Here are some arguments that physician organizations will make in attempting to erect barriers:

Admitting Privileges
*Argument:* NPs don’t have admitting privileges. How will they care for hospitalized patients?

*Answer:* Many NPs have admitting privileges. In addition, some physicians don’t have admitting privileges but still get on provider panels by arranging with hospitalists to take care of admitted
patients. Likewise, some NPs have gotten on provider panels by arranging with hospitalists to care for admitted patients. Some community-based providers assert that they do a better job by concentrating on office visits and turning over admitted patients to hospitalists.

**Credentialing**

*Argument:* We don’t know how to credential NPs.

*Answer:* The following is the credentialing information most often asked of NPs:

- Geographic area of practice
- Work history
- Types of patients cared for (e.g., adults, pediatric, OB-GYN)
- Procedures done
- Partners practicing with
- MD collaborator, if required
- States where licensed as NP, license number
- DEA number
- Degrees, year of graduation, and schools attended
- Certification (year, type, and granting agency)
- Specialty training (year and agency giving training)
- Three references
- Are there any suits against you that have resulted in damages? Are you listed with the National Practitioner Data Bank? Are you currently being sued for malpractice?
- Malpractice insurance policy number, carrier, limits, claims made, or occurrence
Appendix 13-D: Sample Fact Sheet on NPs

About NPs

NPs are registered nurses with advanced preparation who provide primary healthcare services in offices, clinics, homes, schools, and nursing facilities; specialty care in offices and hospitals; and acute and critical care in hospitals and other facilities. NPs provide medical and educational services such as these:

- Complete physical examinations
- Health assessments and screenings (e.g., monitoring blood pressure, monitoring blood sugar levels for diabetic patients, giving routine gynecologic exams, and screening for high cholesterol levels)
- Treatment of acute illnesses (e.g., bronchitis, skin infections, urinary tract infections, and gynecologic infections)
- Treatment of chronic medical conditions (e.g., diabetes, high blood pressure, asthma, ulcers, and high cholesterol levels)
- Health counseling services (e.g., smoking cessation, weight reduction, diet and exercise, medications and their side effects, effects of heavy drinking, and effects of high blood pressure on long-term health)
- Procedures such as suturing, skin biopsies, and lumbar puncture

**Education Requirements**
NPs must complete a 2-year master’s degree program in addition to obtaining an undergraduate college degree. Many NPs have or are getting doctoral degrees. All NPs have advanced training beyond their license as a registered nurse, but some may not have received a master’s degree because this is a relatively new requirement.

**Laws Regulating Activities for NPs Licensure**
NPs have licenses as registered nurses for which they must pass a national board examination. They must then pass an additional national board examination to become certified as an NP.

**Diagnosis and Treatment**
NPs may diagnose and treat patients under their own license. The NP determines when consultation with a physician or other health professional is necessary.
Scope of Practice
All primary care evaluations, procedures, and treatments are within the scope of practice for NPs. In addition, NPs may assist with surgery, do sigmoidoscopies, oversee exercise stress testing, excise skin lesions, suture, and perform many of the procedures needed in acute care. NPs in most states may write for both controlled and noncontrolled medications without the cosignature of a physician.

Malpractice Actuarials
Lawsuits against NPs are rare. The rate of lawsuits against NPs is low, compared with the rate for physicians.

NPs may be sued for malpractice, and the physician affiliated through the written agreement (if one exists) may be named as codefendant. However, the physician is not automatically considered to be liable for a colleague NP’s negligence.

Reimbursement
Medicare and Medicaid reimburse NPs directly, as do Blue Cross and many other insurers. Although third-party payers are not required by law to reimburse NPs, many do so.
Employer Familiarity with NP Services

A recent informal survey of employers revealed the following:

- Company presidents are familiar with NPs because they are seeing NPs when they themselves visit the “doctor.”
- Company presidents have reported satisfaction with the care they received from NPs.
- Employers are hungry for quality healthcare plans that offer savings on premiums.
Chapter 14: Standards of Care for Nurse Practitioner Practice

The traditional definition of standard of care has been “such reasonable, ordinary care, skill, and diligence as used by practitioners in good standing in the same general type of practice, in similar cases.” Today, nurse practitioners (NPs) and other clinicians are judged not only by what other clinicians would do but also by what is best for the patient, as judged by evidence. Evidence is well designed and conducted research. Today, the standard of care addresses these questions:

- Did the clinician do the right thing at the right time?
- Was effective care provided to the patient?
- Was care provided safely and in an appropriate time frame?
- Was the outcome as good as expected, given the patient’s condition and personal
characteristics and the current state of medical science?

**Who Is Monitoring the Standard of Care?**

In the past, compliance with the standard of care was voluntary, performance was not measured or reported to the public, and often, the standard of care for a particular set of circumstances became clear only after a mistake was made, a lawsuit was filed, expert witnesses were hired, dual versions of the standard of care were argued by both sides of a malpractice case, and a jury accepted one side’s version. Today, while the standard of care for NPs still may be scrutinized in a court of law, it is recognized that a minimum acceptable level of care can be determined outside the judicial system by consensus, with participation by consumers, providers, and agencies. For example, the American Diabetes Association has a document “Standards of Medical Care in Diabetes” available from the organization’s journal website. And in the past 3 years, at least 20 organizations, including state health departments, national specialty organizations, state medical boards, and the Centers for Disease Control have developed standards of care for treating chronic noncancer pain with opioids. Clinicians whose practice is not within the standards proposed by a government or
professional organization will have, if sued, a difficult time finding an expert to support the clinician’s decisions. The standards that are being developed will be continually reassessed and reset on the basis of research outcomes, analysis of costs and benefits, and the results of patient satisfaction measures.

Some payers, especially Medicare, set their own standards of care for specific conditions and specialties and adjust reimbursement based on a practice’s report that Medicare’s standards have been met. For example, Medicare asks clinicians to report the percentage of patients aged 18–75 with diabetes whose most recent HbA$_{1c}$ during the year was greater than 9.0% or the result was missing or the test was not performed. A full list of measures is available from the Centers for Medicare & Medicaid Services website.

Corporate and government purchasers of health services have joined medical and nursing professional organizations, licensing boards, and the judicial system in setting standards for healthcare providers. Standards of care are being monitored, publicized, and changed by the government and by several national consumer-oriented groups. Traditionally, standards of medical
and nursing care were developed by clinicians and monitored by these groups:

- Professional societies
- State legislatures and state agencies
- Licensing boards
- Accreditation commissions
- The judicial system
- Employers

Standards of care are now being set, modified, monitored, and publicized by certain self-appointed consumer-oriented agencies, as well as government agencies. Those groups include:

- The National Committee for Quality Assurance (NCQA)
- The Joint Commission
- The Agency for Healthcare Research and Quality (AHRQ)
- Medicare

**Professional Societies**
The American Academy of Nurse Practitioners (AANP) has written standards for the process of care (see *Exhibit 14-1*).

**EXHIBIT 14-1 AANP Process of Care Standards**

**PROCESS OF CARE**
The nurse practitioner utilizes the scientific process and national standards of care as a framework for managing patient care. This process includes the following components.

A. ASSESSMENT OF HEALTH STATUS

- Obtaining a relevant health and medical history.
- Performing a physical examination based on age and history.
- Performing or ordering preventative and diagnostic procedures based on the patient’s age and history.
- Identifying health and medical risk factors.

B. DIAGNOSIS

The nurse practitioner makes a diagnosis by:

- Utilizing critical thinking in the diagnostic process.
- Synthesizing and analyzing the collected data.
- Formulating a differential diagnosis based on the history, physical examination, and diagnostic test results.
- Establishing priorities to meet the health and medical needs of the individual, family, or community.
C. DEVELOPMENT OF A TREATMENT PLAN

The nurse practitioner, together with the patient and family, establishes an evidence-based, mutually acceptable, cost-awareness plan of care that maximizes health potential. Formulation of the treatment plan includes:

- Ordering and interpreting additional diagnostic tests.
- Prescribing or ordering appropriate pharmacologic and nonpharmacologic interventions.
- Developing a patient education plan.
- Recommending consultations or referrals as appropriate.

D. IMPLEMENTATION OF THE PLAN

Interventions are based upon established priorities. Actions by the nurse practitioner are:

- Individualized.
- Consistent with the appropriate plan for care.
- Based on scientific principles, theoretical knowledge, and clinical expertise.
- Consistent with teaching and learning opportunities.
E. FOLLOW-UP AND EVALUATION OF THE PATIENT STATUS

The nurse practitioner maintains a process for systematic follow-up by:

- Determining the effectiveness of the treatment plan with documentation of patient care outcomes.
- Reassessing and modifying the plan with the patient and family as necessary to achieve health and medical goals.

CARE PRIORITIES

The nurse practitioner’s practice model emphasizes:

A. Patient and family education
   - The nurse practitioner provides health education and utilizes community resource opportunities for the individual and/or family.

B. Facilitation of patient participation in self care
   - The nurse practitioner facilitates patient participation in health and medical care by providing information needed to make decisions and choices about:
Promotion, maintenance, and restoration of health
Consultation with other appropriate healthcare personnel
Appropriate utilization of healthcare resources

C. Promotion of optimal health
D. Provider of continually competent care
E. Facilitation of entry into the healthcare system
F. The promotion of a safe environment

INTERDISCIPLINARY/COLLABORATIVE RESPONSIBILITIES

As a licensed, independent practitioner, the nurse practitioner participates as a team leader and member in the provision of health and medical care, interacting with professional colleagues to provide comprehensive care.

ACCURATE DOCUMENTATION OF PATIENT STATUS AND CARE

The nurse practitioner maintains accurate, legible, and confidential records.

RESPONSIBILITY AS PATIENT ADVOCATE
Ethical and legal standards provide the basis of patient advocacy. As an advocate, the nurse practitioner participates in health policy activities at the local, state, national, and international levels.

QUALITY ASSURANCE AND CONTINUED COMPETENCE

Nurse practitioners recognize the importance of continued learning through:

A. Participation in quality assurance review, including systematic, periodic review of records and treatment plans.
B. Maintenance of current knowledge by attending continuing education programs.
C. Maintenance of certification in compliance with current state law.
D. Application of standardized care guidelines in clinical practice.

ADJUNCT ROLES OF NURSE PRACTITIONER

Nurse practitioners combine the roles of provider, mentor, educator, researcher, manager, and consultant. The nurse practitioner interprets the role of the nurse
practitioner to individuals, families, and other professionals.

RESEARCH AS BASIS FOR PRACTICE

Nurse practitioners support research by developing clinical research questions, conducting or participating in studies, and disseminating and incorporating findings into practice.


State Legislatures and State Agencies

Some states address NP standards of care in their laws; for example, Indiana law states:

The following are standards for each nurse practitioner:

1. Assess clients by using advanced knowledge and skills to:
   a. Identify abnormal conditions.
   b. Diagnose health problems.
c. Develop and implement nursing treatment plans.
d. Evaluate patient outcomes.
e. Collaborate with or refer to a practitioner as defined in IC 25-23-1-19.4, in managing the plan of care.

2. Use advanced knowledge and skills in teaching and guiding clients and other health team members.

3. Use appropriate critical thinking skills to make independent decisions, commensurate with the autonomy, authority, and responsibility of a nurse practitioner.

4. Function within the legal boundaries of their advanced practice area and shall have and utilize knowledge of the statutes and rules governing their advanced practice area, including the following:
   a. State and federal drug laws and regulations.
   b. State and federal confidentiality laws and regulations.
   c. State and federal medical record access laws.

5. Consult and collaborate with other members of the health team as appropriate to provide
reasonable client care, both acute and ongoing.

6. Recognize the limits of individual knowledge and experience, and consult with or refer clients to other health care providers as appropriate.

7. Retain professional accountability for any delegated intervention, and delegate interventions only as authorized by IC 25-23-1 and this title.

8. Maintain current knowledge and skills in the nurse practitioner area.

9. Conduct an assessment of clients and families which may include health history, family history, physical examination, and evaluation of health risk factors.

10. Assess normal and abnormal findings obtained from the history, physical examination, and laboratory results.

11. Evaluate clients and families regarding development, coping ability, and emotional and social well-being.


13. Develop individualized teaching plans with each client based on health needs.

14. Counsel individuals, families, and groups about health and illness and promote attention to wellness.
15. Participate in periodic or joint evaluations of service rendered, including, but not limited to, the following:
   a. Chart reviews.
   b. Client evaluations.
   c. Outcome statistics.

16. Conduct and apply research findings appropriate to the area of practice.

17. Participate, when appropriate, in the joint review of the plan of care.

_Citation_: IND. ADMIN. CODE tit. 848, r. 4-2-1.

**Licensing Boards**

Licensing boards carry out the statutes of the state and write and administer rules and regulations for nursing practice, based on statute. Licensing boards enforce standards in the following ways:

- Ensure that qualifications are up to date by authorizing licensing
- Respond to complaints from consumers, employers, colleagues, or patients
- Follow up on malpractice awards monitored through the National Practitioner Data Bank to determine whether a nurse was grossly negligent in providing care
Boards of nursing do not test NPs nor do audits of NP practices. An NP who is sued for malpractice will not necessarily be investigated by the state board of nursing. If, however, a judge, attorney, or plaintiff reports a nurse for suspected gross negligence, the board of nursing will investigate. And a board of nursing likely will find out about malpractice cases against its licensees through the National Practitioner Data Bank and may decide to investigate an NP whose name appears there.

**Accreditation Commissions**

The Joint Commission has accredited and monitored hospital practice and now evaluates health plans, clinics, and medical groups through an accreditation program. The accreditation program is voluntary; however, hospital accreditation has become synonymous with staying in business. Health plan accreditation is also becoming a business necessity. Clinics and medical practices are not routinely accredited, but it is reasonable to expect that accreditation may become a standard in the future.

Through accreditation, committees set standards and conduct site visits to ensure that the standards are met. Providers of health care want to publicize
the fact that they are accredited, so they make sure they meet the current standards.

The Joint Commission requires the hospitals it accredits to assure that its providers, including advanced practice nurses, are evaluated for competency through Ongoing Professional Performance Evaluation (OPPE) and, for newly hired providers, Focussed Professional Practice Evaluation (FPPE). These evaluations cover six domains: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Each facility must develop suitable methods for evaluating the competency of its providers in these six domains.\(^3\)

**The Judicial System**

The judicial system becomes involved in NP practice only when a patient is injured and files a lawsuit. A healthcare provider’s negligence (or lack thereof) is decided by a judge or jury on the basis of the law and the facts of the case. In a court case, each side may present, through expert witnesses, their interpretation of the standard of care. The plaintiff will argue that the standard of care has been violated. The defendant is likely to argue that there has been no violation of the standard of care.
When a judge or jury accepts one side’s version of the standard of care, that version is affirmed for future cases and for healthcare providers, because previous case decisions (precedent) affect future decisions.

Although one organization may publish one standard of care and an expert may testify to an alternate version of the standard of care, the judicial system is the final arbiter of standards.

**Employers**

Some employers develop performance standards for NPs. The following is an example of an employer-generated performance standard for NPs, addressing patient education:

- **Criterion for evaluation:** Provides health education to patients about ways to improve, promote, and maintain their health status, including but not limited to providing educational information on disease/disease processes, self-care practices, and positive lifestyle choices.
- **Performance standards:**
  - Assesses learning capabilities and readiness of population or individuals, and tailors education to meet age, developmental, and educational needs.
- Prioritizes learning needs and documents them accordingly.
- Ensures that time frame and subject matter are appropriate for target audience or individual.
- Utilizes appropriate teaching materials.
- Initiates, designs, and completes educational programs for patients, families, and targeted audiences.

(Exceeds) Demonstrates a high degree of effectiveness in fulfilling standard as observed by supervising physician.4

The National Committee for Quality Assurance

The National Committee for Quality Assurance (NCQA) is a consumer-oriented group directed by representatives from major employers, insurers, and the government. The NCQA accredits managed-care organizations (MCOs) and health plans. It has developed a set of clinical performance measures and patient satisfaction surveys that the group believes represent the consumer’s interests. Those performance measures are being applied to health plans around the country, and the results of the measures are being reported in the news media. Health plans voluntarily collect the performance data, hoping to rate high, receive accreditation and media attention, and attract more enrollees.
Health plans and MCOs turn to medical groups and physician practices for much of the performance data. One prominent set of performance measures is the Health Plan Employer Data and Information Set (HEDIS). The NCQA changes HEDIS measures from time to time, so NPs must order the NCQA’s materials or check its website to ascertain the current measures. Some examples of HEDIS measures follow:

1. Breast cancer screening  
   *Measure:* Female patients aged 50 to 74 had at least one mammogram in the past 2 years.

2. Cervical cancer screening  
   *Measure:* Women aged 21 to 64 had at least one Pap smear during the past 3 years.

3. Prenatal care in the first trimester  
   *Measure:* Pregnant women had prenatal care in the first trimester.

4. Checkups after delivery  
   *Measure:* Women had a postpartum visit 21 to 56 days after delivery.
Agency for Healthcare Research and Quality

The Agency for Healthcare Research and Quality (AHRQ) is a government agency with the mission of improving quality, safety, and efficiency in healthcare. In the past, the AHRQ convened panels of experts that developed standards on certain illnesses. Now, the AHRQ publishes a compendium of guidelines from a wide variety of organizations and agencies in the AHRQ National Guideline Clearinghouse at [https://www.guideline.gov](https://www.guideline.gov).

Among the many guidelines available through the Clearinghouse are:

- Clinical practice guideline: acute otitis externa (2014)
- Screening for breast cancer (2016)
- Low back pain medical treatment guidelines (2014)
- VA/DoD clinical practice guideline for the management of chronic kidney disease in primary care (2014)
- Bipolar disorder: the assessment and management of bipolar disorder in adults, children, and young people in primary and secondary care (2014)

The Clearinghouse website, while encouraging clinicians to use the guidelines, states that the
recommendations may not be appropriate for use in all circumstances and that decisions to adopt any particular recommendation must be made in light of available resources and circumstances presented by individual patients.

**Medicare**
As part of an initiative to increase the quality of care to beneficiaries, Medicare, beginning in 2006, asked physicians to voluntarily report their performance on specified quality measures. That reporting program is continuing to be refined. Information on these measures is available online (http://www.cms.gov). Search for “Physician Quality Reporting System” or “Merit-Based Incentive Payment System (MIPS).”

**How Should NPs Keep Current on Standard of Care?**
NPs should use traditional methods of keeping current, including the following:

- Books
- Newsletters and listserves
- Websites, such as Medscape.com, Epocrates.com, and guideline.gov and those of relevant professional societies
- Continuing education seminars
- Journals
- Other practitioners

In addition, and in light of newly emerging standards, NPs should also consult these sources:

- Audit tools used by MCOs
- Accreditation guidelines supplied by accrediting organizations
- NCQA standards
- AHRQ standards or guidelines
- State law, if standards are mandated by law

**Credentialing**

Another standard being developed under managed care is credentialing. Credentialing for most health plans is now being conducted largely by one nonprofit organization, the Council for Affordable Quality Healthcare (CAQH). For more information about the organization and how to get credentialed through CAQH, visit the website [http://www.caqh.org](http://www.caqh.org). Given the quantity and detail of questions being asked about applications for admission to provider panels, it is reasonable to expect that a set of standards based on credentials will emerge.

**Utilization**

Under managed care, not all standards for clinicians are related to the quality of patient care. Some
standards look at quantity of care delivered. For example, NPs can expect that health plans will be looking at NP utilization of emergency room visits, hospitalization, specialist visits, and diagnostic testing.

**Patient Satisfaction**
There are emerging standards regarding patient satisfaction. For example, some health plans want practices to answer a telephone call within five rings and patients to be able to get appointments within 72 hours, and do not want patients to have to wait more than 20 minutes after arrival for their appointments. These standards have evolved from research showing that patients are annoyed by unanswered telephones, long waits for appointments, and sitting in waiting rooms. Because health plans compete for patients and medical practices compete for admission to provider panels, it is reasonable to expect that certain customer service standards that are currently informal will be more forthrightly stated in the future.

**NP Competencies**
The National Organization of Nurse Practitioner Faculties (NONPF) has developed a list of core competencies that all students should have upon graduation from either a master’s program or a DNP
program. That list is available through the organization’s website.

Other organizations have published core competencies for those NP who enter specialties. For example, the Oncology Nursing Society has published competencies for the NP who provides cancer care. The Emergency Nurses Association has published competencies for NPs who provide emergency care.

Employers also may establish their own set of competencies. For example, a hospital administration may decide that an acute care NP must be competent at placing a central line. Competency may be established through a teaching and evaluation process. The hospital might require that the NP complete a set of readings, view five line placements, and then perform five under supervision before the NP may place a line without supervision.

There are no national standards for judging competency at specific procedures; however, if something goes wrong, for example, in a hospital setting during a central line placement and the NP’s competency is challenged as part of a lawsuit, then the employer’s requirements as well as the
requirements of similar hospitals may be cited by a plaintiff as examples of standards. For example, if an NP is sued because a patient suffered an injury during central line placement, the plaintiff may assert that the NP was incompetent and that the hospital should have known that. If the NP was hired recently and performed the line placement on his or her own without supervision, the plaintiff will subpoena any information on the hospital’s policies on competencies. If the hospital had a requirement that all acute care NPs perform solo central line placements only after being supervised for five placements and being signed off by a supervisor and this NP hadn’t gone through the five supervised line placements and supervisor sign-off, then the NP and the hospital are not in a good defensive position and may lose the case.

The important points about competency lists are:

- Each organization should determine which competencies are required for an NP’s position. First, answer the question of whether there is a national standard. NONPF’s core competencies are a national standard for all NPs. In addition, there may be national standards set by specialty societies. If there is no national standard, there may be competencies set by other, similar
hospitals, agencies, or practices and by the NP’s own organization.

- NPs who are new to their positions should ask administrators whether there are competency requirements in place for the NP’s position.
- When setting competencies, organizations should research what other, similar organizations are doing and tailor the competency lists to the more rigorous standards.
- Organizations should tailor the competencies to the specific role. For example, using primary care competencies for acute care positions does not make sense.
- NPs and their employers should make sure that any stated competencies are met.
- Having no stated competencies isn’t going to be helpful if an NP’s competency is challenged.

Notes


Chapter 15: Measuring Nurse Practitioner Performance

Standards of care and measures of performance are interrelated. Measures of performance are used to determine the extent to which standards of care are met. Measuring performance without standards is like playing a game without rules. Setting standards without measuring performance is like making laws when there are no police to enforce the laws.

Measuring Quality
In general, the quality of clinical care is assessed by asking and answering the following questions:

- Did the clinician do the right thing?
- Was the care effective?
- Was care given in an appropriate time frame?
- Was the outcome as good as could be expected, given each patient’s condition and personal
characteristics and the current state of medical science?

The standard of care for a particular episode of illness is assessed by asking and answering these questions:

- What was the correct treatment?
- What was the correct timing of treatment?
- What was the correct teaching or counseling?

Measures of the standard of care ask and answer these questions:

- Did the clinician follow the treatment standards developed by one of the payers, accrediting organizations or consumer-oriented groups?
- Did the patient’s problem resolve?
- Did the problem resolve within the expected time frame?
- If the problem did not resolve and the clinician did not expect that it would resolve, did the patient’s quality of life improve or did bothersome symptoms decrease in severity?
- For a patient with a chronic condition, did the patient’s test numbers fall within a range that is indicative of “control”?
- Were the resources used to solve the problem in line with what would be expected for that problem?
- Was the patient satisfied with the experience of care?
- Was the patient satisfied with the outcome?

**Multiple Measures, Multiple Measurers**

Nurse practitioner (NP) performance is evaluated on several levels: productivity, utilization, and patient satisfaction, as well as the quality of clinical decision making. An NP’s performance is judged by employers, patients, health plan auditors, government quality improvement programs, peers, and possibly even researchers.

If an NP’s performance is employer defined, then the NP will need to ascertain the values of the employer. To one employer, good performance might be synonymous with high billings, which could, because of time constraints, preclude giving adequate attention to each patient. For another employer, good performance might mean high scores on surveys of patient satisfaction. An NP who satisfies patients might not be a high biller. To yet another employer, good performance might mean close communication with the physician consultant, while in another practice it might mean independent functioning without the need for communication with a physician.
If performance is defined by the health plan, then a good performer is one who uses expensive resources—hospitals and emergency rooms—relatively infrequently.

If an NP’s performance is defined and measured by Medicare, then an excellent performer is one who has done well on the Merit-Based Incentive Payment System (MIPS) measures; for example, was the NP within a desired percentile, when compared with other providers in the specialty, on measures such as these:

- Percentage of the practitioner’s female patients aged 50–74 who were screened appropriately for breast cancer with a mammogram?
- Percentage of children aged 3–18 who were diagnosed with pharyngitis who were prescribed an antibiotic and tested for Group A Streptococcus.
- Percentage of patients age 18 and older diagnosed with heart failure with a prior or current ejection fraction of less than 40% who were prescribed a beta blocker either in a 12-month period when seen on an outpatient basis or on discharge from a hospital.

If an NP’s performance is defined by present performance measures developed by consumer-
oriented groups, such as the National Committee for Quality Assurance (NCQA), an NP who sees that all children are properly immunized, who gets patients to quit smoking, and who raises the functional status of elderly patients will be seen as a good performer.

If an NP’s performance is defined by peers, a good performer is likely to be an expert diagnostician who shares knowledge willingly with other NPs and is compatible with other clinicians and staff.

If performance is defined by researchers, a good performer is one who meets the particular testing criteria studied by the researcher.

Finally, if performance is defined by patients, a good performer is one who does not make the patient wait more than 20 minutes in the waiting room before being seen, is patient and polite, and does not miss a serious diagnosis.

There is no single, widely accepted set of measures of an NP’s worth or performance. For any practice setting, an NP will need to determine what performance measures apply, what is important to the employer and the payer, and how to do well on those measures. In this chapter, several measures of performance are summarized.
Productivity Definitions
A definition of productivity may depend on the setting and the method of payment to the practice.¹

In a practice that gets reimbursed according to a fee-for-service structure, a productive NP is one who sees many patients at a 99213 level or above and bills often for additional services that generate revenue, such as suturing, incision and drainage, and endometrial biopsy.

In a practice that receives mostly capitated payments, an NP who efficiently handles a large panel of patients with little use of the practice’s resources—staff, materials, time—is a good performer.

If an NP is employed by a nursing home, productivity may mean keeping elderly patients out of the hospital and imparting to their families the feeling that their loved one is being closely monitored and well cared for.

Measurement
In a fee-for-service practice, a simple way of measuring performance is to set the number of visits conforming to the evaluation and management
Current Procedural Terminology (CPT) codes. For example, good performance in an office setting could be set at 20 visits at levels 99211 to 99215 per day. One would not want to set a specific code as a performance measure because it is the patient’s need for evaluation and management services that determines the CPT code billed and a provider cannot predict what level of visit will be needed.

In a capitated practice, good performance could be set at maintenance of an 1,800-member panel of patients, with patient satisfaction as measured by a particular tool at 80% or above.

In a nursing home practice, good performance could be measured by decreasing over a previous year the number of hospital visits among the nursing home’s residents.

In a hospital practice, good performance could be decreasing the percentage of patients readmitted within 30 days of discharge compared to the previous year.

**Housekeeping Performance Measures**
NPs may have more experience with “housekeeping” forms of performance measurement than with substantive forms, such as the Physician Quality Report System, MIPS, or the Health Plan Employer Data and Information Set (HEDIS). For example, many NPs’ charts are audited for such things as clear labeling of allergies, initialing and dating of laboratory results, patient name on every page, and a completed problem list. While these are important matters, NPs should expect that audits will become increasingly more oriented toward outcomes.

**National Committee for Quality Assurance Measures of Clinical Performance**

Nonclinicians have begun to get involved in measuring clinical performance. After putting out a call for performance measures, NCQA received 800 suggestions and developed HEDIS and a set of clinical performance measures aimed largely at primary care providers. Presumably HEDIS is some indication of what employers, consumers, and health plan executives think is important for healthcare providers to accomplish. The HEDIS measures are constantly reconsidered and refined.
Among the evaluation measures set by HEDIS for primary care providers are these:

- At least 80% of female patients aged 50 to 74 had at least one mammogram in the past 2 years.
- At least 80% of women aged 21 to 64 had at least one Pap smear during the past 3 years.
- At least 97% of pregnant women began prenatal care during the first trimester of pregnancy.

Some of these data are collected from the Centers for Medicare & Medicaid Services 1,500 (billing) forms. Other data are collected by auditors who review charts or from surveys.

HEDIS also looks at these indicators:

- Whether women had postpartum visits 21 and 56 days after delivery
- Whether patients who were hospitalized for mental illness and were seen on an outpatient basis by a mental health provider within 30 days after discharge

HEDIS measures change from time to time. For the current measures and benchmarks, visit the website.²

Other Measures
HEDIS is not the only set of performance measures, and NCQA is not the only organization looking after consumer interests and rating health plans and providers. Among the other organizations publishing performance measures are the Centers for Medicare & Medicaid Services, The Joint Commission, certain managed-care plans, certain state health departments, and the Agency for Healthcare Research and Quality. The performance measures advocated by these organizations overlap to some extent.

**Formal Research**

Researchers who have studied NPs’ performance and compared it with physicians’ performance have looked at the following measures:

- Whether NPs took a thorough history and gave appropriate treatment to a patient with a particular set of symptoms and history.  

- Whether NPs performed or followed up on a set of primary care tasks, such as follow-up on a low hematocrit and obtaining appropriate cancer screening tests.  

- Whether patients reported, on a survey, that their experience of care was satisfactory.  

- Whether NPs’ care was cost-effective when all of the costs of care were tallied.
- Whether the level of care in nursing homes was improved by NP participation.\textsuperscript{7}
- Whether NPs controlled the blood pressure of patients diagnosed with hypertension to below 140/90.\textsuperscript{8}

The performance of NPs was found to be at least as good as physicians’ on these measures.

**Patient Ratings**
Many difficulties and intervening factors become apparent when one attempts to get patients to rate NP performance. Individuals have their own set of beliefs about health and illness, which may affect their interpretation of the quality of care given to them. Individuals may focus on nonclinical aspects of care that affect their experience. Individuals may feel compelled to give a provider a good rating, fearing a turn in the relationship if they are critical. And surveys may reach a patient at a date much later than the care was given, when the individual has forgotten the bad or the good aspects of the care.

Nevertheless, patient-rated measures of performance are to be taken seriously. Whether or not an NP believes a patient’s rating to be valid, much information can be gleaned from patient survey results. For example, if a patient’s
experience of care was influenced negatively by a grouchy receptionist, then attitude adjustment on the part of the receptionist is a relatively easy alteration for a practice to make.

Health plans, practices, and facilities often conduct patient surveys, and NPs would be wise to get copies of these various surveys and their results and to conduct visits and make corrections in problem areas accordingly.

Consumers are able to review other patients’ experiences with clinicians through commercial websites and health plan sites. NPs thus are also advised to search such sites for comments about themselves and to make adjustments if needed.

**Peer Review**
Some accrediting organizations require that hospitals and medical offices conduct regular peer review. There are many peer review tools in the medical and nursing literature.

**Utilization**
Because hospitals, emergency rooms, and specialists are high cost centers for health plans, health plans want providers to keep admissions and referrals to the emergency room and specialists at a
minimum. Whether an NP works for a physician or is in independent practice, the NP can expect that in the world of managed care, someone will be looking at the numbers of admissions and referrals.

How to Get an “A” on Performance Report Cards
An NP who wants to shine on performance evaluations will determine who in a work setting is interested in what measures and will adapt his or her practice accordingly. If there are no adopted performance measures, the NP may want to adopt the self-evaluation routine given in Appendix 15-A.

The number of hoops through which NPs must jump continues to rise. Many more tasks are coming under scrutiny than ever before.

NPs who are given only 15 minutes to take care of a patient’s episodic problem know the frustration of quickly leafing through a patient’s record to check on details. Whether a patient has been a smoker or has been advised to quit or is up to date on healthcare maintenance—mammograms, immunizations, and Pap smears—often takes longer than 15 minutes to ascertain, even when the patient is sitting in the adjacent chair. Electronic medical records may decrease the amount of time NPs
spend on healthcare maintenance in that some systems alert the clinician about tests needed and questions to ask. On the other hand, NPs may spend more time in the future on healthcare maintenance because they are reminded about what is needed and they attend to those needs.

Documentation of health maintenance checks was a problem long before HEDIS, MIPS, and even the term primary care provider came into common usage. Every primary care provider is familiar with the feeling of uneasiness that comes from scanning a chart for an established patient that contains no record—all in one place—of routine screening efforts and results. Occasionally, some thoughtful physician assistant, NP, or physician will have summarized a patient’s chart in a progress note. The trick then becomes finding that progress note.

Some practices keep flowcharts to document healthcare maintenance. Some electronic medical records track and/or remind clinicians to attend to healthcare maintenance tasks. Practices that track health maintenance are far ahead of those that do not keep such information in a central place. But even practices that keep flowcharts need to know how health plans and Medicare have decided to grade.
Ensuring Compliance

A simple tool, kept in the front of a chart or in a special section called “Performance Measures” or some similar title, can prompt busy providers to ask the pertinent questions; arrange the pertinent screens, tests, medications, classes, or counseling; and note the date when the work was done. Some electronic medical records are programmed to prompt clinicians to address health maintenance. One format for a tool is given in Appendix 15-B.

NPs who are employees can be motivated to keep checklists and flowcharts up to date by tying compliance to bonuses, conducting internal quality assurance audits and giving feedback to providers on their performance, and including this activity in job descriptions and evaluation tools.

Self-employed NPs will find their own rewards in keeping up with outside measures of performance. Finding a healthcare provider is no longer a matter of word of mouth. Patients usually go to providers who will be reimbursed by the patient’s health plan. Retention on provider panels is likely to be contingent on satisfaction of performance measures. Those providers who meet the standards now being set by consumer-driven groups will end
up with a thriving practice, which, after all, is the most traditional measure of performance.

The organizations doing the measuring, grading, and reporting have the mission of helping consumers. How logistically difficult it is for health plans and providers to comply with these measures is not the main concern of these organizations.

The hoops are not limited to clinical performance measures. HEDIS has included measures of access and availability of care, patients’ satisfaction with their care experience, health plan stability, utilization of selected services, cost of care, and such services as new member orientation and translation services.

Strategies for complying with the performance criteria set by the NCQA and Medicare include increasing clinicians’ and administrators’ knowledge of specific performance measures, delegating responsibility for continuous quality improvement, implementing systems for tracking compliance, attending to patient satisfaction, addressing the functional level of elderly patients, and rewarding clinicians and practice managers for compliance and high scores.

Notes


Appendix 15-A: NP Self-Evaluation

To fare well on clinical performance evaluations, an NP in office practice should set up a routine for self-evaluation. Tailor the questions to your own patients and practice. Following is an example:

1. For each visit, have I asked the patient the following questions:
   - Are you smoking? (If so, advise patient to quit.)
   - Did you get an appointment promptly?
   - How long did you spend in the waiting room? Was the wait too long or was it acceptable?
   - Has this visit satisfied your expectations?

2. On each visit, have I consulted the chart for the following:
   - Up-to-date immunizations?
   - Up-to-date cancer screening: Pap, mammogram, colonoscopy?
   - Eye exam in the past year for diabetic patients?
Follow-up visit within 6 weeks of giving birth for postpartum patients?

3. If a patient has been hospitalized for mental illness, was the patient seen by a mental health clinician within 30 days after discharge?

To do utilization self-monitoring, for each quarter, keep a notebook with this information:

- Patient admissions to hospitals
- Referrals to the emergency department
- Referrals to specialists
- Number of patients seen per day
# Appendix 15-B: Health Maintenance Flowchart

**Name:** 
**Date of birth:** ____________________  
**Date of birth:** __________________________  
**Patient number:** ________________________  

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*Organizations’ recommendations on age ranges vary and change from time to time. Please check for current recommendations of a nationally recognized organization.

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<tr>
<td>Hep A</td>
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*Vaccine recommendations change from time to time. Please consult Centers for Disease Control recommendations for the current year.*
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<td>Rotavirus</td>
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*Vaccine recommendations change from time to time. Please consult Centers for Disease Control recommendations for the current year.*
Chapter 16: Resolving Ethical Dilemmas

The Basics of Biomedical Ethics

Difference Between Ethics and Law

There is overlap between ethics and the law. Ethics is a branch of philosophy that discusses and analyzes what is good for an individual and for society. With ethical questions, rarely are the answers black and white. While there are individuals who devote their life to the study of ethics, anyone may analyze a specific situation and come to an opinion about what is best. An individual may think one solution to an ethical dilemma is correct, but another individual may decide otherwise. There is no overall referee on this earth. There are, however, guiding principles.

Laws set rules about what is right or wrong, permitted or illegal. Law can be made by state legislatures, the United States Congress, regulatory agencies, or courts. Laws may attempt to be black and white about what is right and wrong, but they
rarely succeed. With a legal dilemma, a law may state what is prohibited, but the line between right and wrong often is subject to gray areas and conflicting interpretations, just like ethics. Arguments can be made about what a law means and arguments can be made that a law does or doesn’t apply to a specific situation.

In nursing and in medicine, the guiding general rule of ethics is “do no harm.” This principle is attributed to the Greek physician Hippocrates, who died in 370 BC. His statement was “Make a habit of two things: to help; or at least to do no harm.” The clinician who employs Hippocrates’s guidance, every time something is ordered or advice is given, will have a sound basis for ethical practice.

This book focuses on the law as it relates to nurse practitioners (NPs). The author does not profess to be an expert on ethics. However, because of the overlap between ethics and the law, faculty members have requested that the author address the basics of biomedical ethics.

Academics in nursing and medical ethics use these terms:
**Beneficence:** Benefit others by preventing harm, removing harmful conditions, or affirmatively acting to benefit another or others, often going beyond what is required by law

**Justice:** Treat others equitably, distribute benefits/burdens fairly

**Fidelity:** Loyalty, fairness, truthfulness, advocacy, and dedication in relationships; includes promise-keeping, truth-telling, and fulfilling commitments

**Non-maleficence:** Obligation not to inflict harm, balancing unavoidable harm with benefits of good achieved

**Respect for autonomy:** Acknowledge a person’s right to make choices, to hold views, and to take actions based on personal values

The reader who wants to explore biomedical ethics in depth is invited to visit the websites of one of the academic centers for biomedical ethics.

For a practical view of the ethical dilemmas inherent in nursing, view “The Code of Ethics for Nurses from the American Nurses Association,” available at the organization’s website. This document covers
relationships with patients (such as protection of privacy and respect for right of self-determination), but also relationships with coworkers.

Sometimes, law and ethics intersect in the courtroom. For example, a nurse in Michigan, Roberto Landin, was terminated from his job at a nursing facility, shortly after he reported a patient safety problem to his supervisor. A patient had died during the night, and the nurse caring for the patient had reported the man died after falling out of bed and hitting his head. Landin, who was very familiar with the patient after caring for him for 18 months, reported for work the next morning and looked into the patient’s death. He discovered that the nurse had given the patient twice his normal dose of insulin at 9:00 p.m. When the nurse found the patient on the floor at 1:30 a.m., she did not check his blood sugar and did not call a physician or the physician assistant on call. She had not checked on the patient between 9:15 p.m. and 1:30 a.m. Landin wrote a report for his supervisor, saying he thought the nursing care was incompetent. Landin was fired a few weeks after that, though the other nurse continued to work. Landin sued the hospital for wrongful termination in violation of public policy. During the trial Landin’s attorney used the American Nurses Association Code of Ethics to show that
Landin was bound by professional ethics to report his findings about the quality of care issue and that public policy calls for protecting patients and for making inquiry into nursing and medical mistakes. This case shows the interaction between law and ethics. There is no law that a nurse must check on a patient at any specified interval and no law that another nurse must or may not report another nurse to his or her supervisor, but the principles of ethics say that nurses must protect patient safety, and therefore nurses have an obligation to understand the treatments being given and provide appropriate monitoring and follow-up. And nurses have an ethical obligation to do something when they feel patients are receiving inadequate care.

There are a multitude of ethical issues that come up in nurse practitioner daily practice, including these:

- Whether or not to disclose to a patient that the NP or someone else at the practice made a mistake regarding the patient’s care
- Whether the availability or lack of reimbursement should determine whether a service is provided
- Whether participation in a research study is the best thing for a patient
- Whether a promise to a patient or family member not to disclose information to a family member or
Whether and when curative treatments should be stopped
When and how to terminate a relationship with a patient
Whether or not to accept a gift or meal from a vendor or pharmaceutical representative
Whether to discuss the deficiencies of a patient’s insurance coverage with a patient
Whether and how to tell a patient you are moving to another practice
Whether and how to inform a patient that you believe the surgeon he or she has chosen is not competent

**Examples**
Consider these four situations.

**Situation 1**
While standing in line at the grocery store, you hear someone yell “Help! This lady is having a seizure!” Behind you, a woman is on the floor, jerking around in a way you know is characteristic of a grand mal seizure. Several people are standing over her, calling out for help. You feel compelled to help but worry that you will get sued if something goes wrong and/or be accused of practicing medicine without a physician collaborator.
Situation 2
You get a letter from a pharmaceutical company inviting you to participate in a round table discussion hosted by the company. There will be 15 attendees, all NPs who provide women’s health care. The topic will be treatment of hypercholesterolemia in the older woman. The company has a prescription product for reducing cholesterol. The letter offers you $500 plus a gourmet dinner. The writer wants to send you a consulting contract.

Situation 3
You are arranging the annual conference for NPs in your state. You have heard from past conference chairs that some pharmaceutical manufacturers will engage in any and all of the following sponsorship activities:

- Purchase booth space in the exhibit hall
- Provide unrestricted grants for general conference overhead in return for a listing as sponsor on the program
- Fund specific speakers, including their speaking fee, travel expenses, slides, and handouts
- Purchase books as gifts for attendees
- Fund the travel expenses of some high-volume prescribers
You have the names and telephone numbers of several drug reps in your area. You are not sure what to ask for or what is appropriate under the federal compliance program guidance for pharmaceutical manufacturers.

**Situation 4**
A patient of yours wants to quit smoking. His health plan will pay for Wellbutrin (bupropion), which is prescribed for depression, but not Zyban (bupropion), the same drug marketed for smoking cessation. You wonder whether it is “insurance fraud” to save the patient money by treating smoking cessation with a prescription for Wellbutrin, given that the medication and dosing is the same as Zyban.

**Analyzing the Ethical Choices Inherent in These Situations**

**Situation 1: Providing Care on the Street**
When faced with a scenario similar to Situation 1, an NP who ignores the person having a seizure is doing nothing illegal. There is no legal requirement that a healthcare provider pay attention to patients, even when a patient is sitting in front of the provider in a clinic. However, most healthcare providers feel an ethical, as well as business, responsibility to
provide care for patients who come to the office. As for the individual who falls down in the street, has a seizure in public, or has had an automobile accident, the individual clinician may make his or her own decision about whether to become involved. The decision will be based on the clinician’s analysis of whether he or she is ethically obligated to respond and whether other considerations outweigh any ethical dictates. Two NPs in the same situation may come to opposite conclusions.

Four forces encourage clinicians to provide care:

1. Fear of a lawsuit for malpractice if they neglect to treat an illness
2. Fear of a charge of patient abandonment if they do not give care
3. The need for compensation
4. Clinicians’ own values, which include their sense of ethical responsibility

**Malpractice**
For a successful malpractice lawsuit, four elements have to be satisfied. First, there must be a duty of care owed to the patient by the clinician. Second, the clinician has to have breached the standard of care. Third, there must be an injury to the patient.
Fourth, the patient’s injury must be causally related to the clinician’s breach of the standard of care.

A clinician who provides care or advice for a person on the street establishes a duty of care. A clinician who walks by without offering advice or a service does not establish a duty of care. Thus, the clinician who chooses not to become engaged is shielded from a lawsuit for malpractice because there is no duty of care.

**Patient Abandonment**

In the case of the woman seizing in the grocery store, a clinician cannot be charged with patient abandonment if the clinician never becomes engaged in the woman’s care. Patient abandonment is defined slightly differently from state to state. It is often addressed on the websites for the boards of nursing. For example, the Colorado Board of Nursing states that for patient abandonment to occur, the registered nurse has to have accepted the assignment and severed the relationship without giving reasonable notice to the appropriate person (such as a supervisor or patient) so that arrangements can be made for care by others. It is not patient abandonment, therefore, to refuse to accept an assignment or a patient–nurse relationship. Therefore, a nurse who walks by a
person in distress on the street cannot be accused of patient abandonment.

**Reimbursement**
In a roadside assistance situation, reimbursement is not an issue, as there is no system under which a clinician can submit a bill for such care. The reimbursable settings of care are office, hospital, nursing home, patient’s home, and domiciliary facility, and there are no procedure codes for the settings “sidewalk” and “grocery store.”

**Ethics**
The clinician faced with a decision to ignore or become involved with an individual in distress will weigh his or her assessment of right and wrong and attempt to come to a decision in which his or her behavior conforms to a standard of right behavior. Some considerations might be as follows:

- Are there other people already helping the individual?
- Are my skills any more helpful than what is already being done for the individual? The NP can help shield the patient’s head from hard or sharp surfaces, but so can the nonclinician bystander. If the NP has no education or experience in emergency medicine, the NP may
not be any more qualified to help than another bystander.

- What, exactly, can I do for the patient? For example, the treatment for seizures is intravenous valium. The NP on the street has no valium to offer a patient. On the other hand, if the situation is that an individual has fallen to the ground, apparently unconscious, and an NP knows cardiopulmonary resuscitation, then there is something the NP can offer.

- Do I have the legal authority to diagnose and treat in this situation? In most states, an NP needs a collaborative agreement with a physician to diagnose and treat, and those agreements do not usually extend to on-the-street encounters.

- Will I feel that I did not meet my own expectations of myself if I pass by without offering help?

- If I were the patient and an NP walked by and saw me, would I want the NP to offer to help?

NPs make situation-by-situation decisions about whether to become involved with clinical care during off hours. There is no legal mandate to offer services. A clinician may choose to become involved or not, depending upon the situation and the clinician’s analysis of what is the humane and reasonable thing to do.
Situation 2: Accepting Gifts or Payment from a Pharmaceutical Company

When a pharmaceutical company offers a clinician substantial remuneration for minimal work, it raises suspicions that the company is looking to create a situation where a clinician feels obligated to prescribe the company’s medication.

Both the pharmaceutical industry and the federal government have adopted guidelines addressing the relationships between clinicians and pharmaceutical companies. The guidelines attempt to provide pharmaceutical companies with a yardstick by which to judge whether a gift or payment from a pharmaceutical company is a kickback to a clinician or a payment at fair market value for personal services rendered.

The questions that separate a kickback from a business arrangement for services are as follows:

- Is the clinician in a position to generate healthcare business for the manufacturer directly or indirectly?
- Is any one purpose of the remuneration to induce or reward the referral or recommendation
of business payable in whole or in part by a federal healthcare program?

- Does the arrangement have the potential to interfere with or skew clinical decision making?
- Does the arrangement or practice have the potential to increase costs to the federal healthcare programs, beneficiaries, or enrollees?
- Does the arrangement or practice have the potential to increase the risk of overutilization or inappropriate utilization?
- Does the arrangement or practice raise patient safety or quality of care concerns?¹

The pharmaceutical industry’s own “Code on Interactions with Healthcare Professionals” provides the following guidance:

> It is appropriate for consultants who provide services to be offered reasonable compensation for those services and to be offered reimbursement for reasonable travel, lodging, and meal expense incurred as part of providing those services. Compensation and reimbursement that would be inappropriate in other contexts can be acceptable for bona fide consultants in connection with their consulting arrangements. Token
consulting or advisory arrangements should not be used to justify compensating healthcare professionals for their time or their travel, lodging, and other out-of-pocket expense. The following factors support the existence of a bona fide consulting arrangement:

- A written contract specifies the nature of the services to be provided and the basis for payment of those services;
- A legitimate need for the services has been clearly identified in advance of requesting the services and entering into arrangements with the prospective consultants;
- The criteria for selecting consultants are directly related to the identified purpose and the persons responsible for selecting the consultants have the expertise necessary to evaluate whether the particular healthcare professionals meet those criteria;
- The number of healthcare professionals retained is not
greater than the number reasonably necessary to achieve the identified purpose;

- The retaining company maintains records concerning and makes appropriate use of the services provided by consultants;
- The venue and circumstances of any meeting with consultants are conducive to the consulting services.²

The Office of the Inspector General (OIG) “Federal Register Notice on the Compliance Program Guidance for Pharmaceutical Manufacturers” issued in 2003 states the following: “In general, fair market value payments to small numbers of physicians for bona fide consulting or advisory services are unlikely to raise any significant concern. Compensating physicians as ‘consultants’ when they are expected to attend meetings or conferences primarily in a passive capacity is suspect.”¹ The OIG Guidance applies to healthcare professionals other than physicians.

Both the Pharmaceutical Research and Manufacturers of America (PhRMA) Code and the OIG Guidance are targeted to the pharmaceutical
industry. It is up to clinicians to get a sense of what is considered right and wrong on their part.

Hence, a clinician faced with Situation 2 should apply the tests now accepted as standard in the industry before accepting the invitation. Specifically, will the NP who accepted the $500 and a fine dinner be more likely than the NP who didn’t to prescribe the company’s medication, even though it will cost the patient or the patient’s insurer much more than a generic product? And, if the answer is no, is the NP being ethical in accepting the money and dinner? Will the NP provide $500 worth of consultative services to the pharmaceutical company at the dinner?

Note that the latest edition of the PhRMA Code prohibits the provision of meals to clinicians, except when accompanied by an educational session in the clinician’s office or hospital, or at a speaker event such as a conference, and it also prohibits the distribution of noneducational items such as pens. The organization decided that even a very small token can influence a clinician.

**Situation 3: Accepting Financial Support from a Pharmaceutical Company**
The PhRMA Code has these caveats about pharmaceutical company involvement in third-party educational or professional meetings:

- Financial support should be given to the conference’s sponsor rather than to an individual participant.
- Responsibility for and control over the selection of content, faculty, educational methods, materials, and venue should remain with the conference organizers.
- Pharmaceutical companies should not provide direct support for conference meals, though a conference director may decide to use general support money to pay for meals.
- Pharmaceutical companies may not support the expenses of participants.

For arrangements between physicians and other persons in a position to make or influence referrals, orders, or prescriptions that do not fit a safe harbor from the anti-kickback rule, the analysis that the OIG recommends is as follows:¹

- What degree of influence does the physician have, directly or indirectly, on the generation of business for the manufacturer?
- Does the remuneration take into account, directly or indirectly, the volume or value of
business generated?
- Is the remuneration more than trivial in value?
- Do fees for services exceed the fair market value of any legitimate, reasonable, and necessary services rendered by the physician to the manufacturer?
- Does the remuneration have the potential to affect costs to any of the federal healthcare programs or their beneficiaries or to lead to overutilization or inappropriate utilization?
- Would acceptance of the remuneration diminish, or appear to diminish, the objectivity of professional judgment?
- Are there patient safety or quality of care concerns?
- If the remuneration relates to the dissemination of information, is the information complete, accurate, and not misleading?

A safe harbor from violation of the anti-kickback is described as follows:

Personal services and management contracts. As used in Section 1128B of the Act, “remuneration” does not include any payment made by a principal to an agent as compensation for the services of the agent, as long
as all of the following seven standards are met:

1. The agency agreement is set out in writing and signed by the parties.
2. The agency agreement covers all of the services the agent provides to the principal for the term of the agreement and specifies the services to be provided by the agent.
3. If the agency agreement is intended to provide for the services of the agent on a periodic, sporadic, or part-time basis, rather than on a full-time basis for the term of the agreement, the agreement specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals.
4. The term of the agreement is for not less than 1 year.
5. The aggregate compensation paid to the agent over the term of the agreement is set in
advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid, or other federal healthcare programs.

6. The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

7. The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.

For purposes of paragraph (d) of this section, an agent of a principal is any
person, other than a bona fide employee of the principal, who has an agreement to perform services for, or on behalf of, the principal.

_Citation: 42 C.F.R. § 1001.952(d)._ 

As described in Situation 3, an NP arranging the annual state conference may arrange for pharmaceutical manufacturers to do the following:

- Purchase booth space in the exhibit hall at which they will distribute information
- Provide unrestricted grants for general conference overhead in return for a listing as sponsor on the program
- Fund specific speakers, including speaking fees, travel expenses, slides, and handouts as long as the information the speakers provide is educational and consistent with patient safety

**Situation 4: Prescribing Medications**

It may be ethical to try to save the patient money, but it is illegal—fraud—to diagnose depression in a patient whose mood is normal so that the patient can get a prescription covered by insurance.

Here is what the U.S. Code says about fraud:
Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice (1) to defraud any healthcare benefit program; or (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any healthcare benefit program, in connection with the delivery of or payment for healthcare benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in Section 1365 of this title), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

_Citation_: 18 U.S.C. § 1347.

Is it fraud if you diagnose “smoking,” and prescribe Wellbutrin? Probably not, because you are not
deceiving anyone. However, the insurer is likely to deny payment for the Wellbutrin.

Is it fraud if you diagnose “depression” and omit any reference to smoking? Yes. Is it fraud if you diagnose “depression” and “smoking” and prescribe Wellbutrin? Probably not. However, ask yourself if you can make the argument, with a straight face, that the patient is both depressed and a smoker, or that he is using nicotine to self-medicate for depression, or that he may be depressed about his smoking. In addition, before taking that route, consider that unless a patient is truly depressed, you may not want to enter that diagnosis unless the patient agrees that he is depressed. In the future, the patient may want to authorize release of his medical record to a prospective employer. If that happens, you do not want the patient to be surprised and upset to find that he has a documented history of depression. Furthermore, are you ready to follow up your diagnosis of depression by addressing that problem in subsequent visits by performing and documenting one of the depression scales? Are you prepared to follow the standard of care for treatment of depression, that is, to treat for 12 months?
A clinician may have the best intentions—to relieve the patient’s problem and save the patient money—but the risk probably outweighs the benefits in these situations.

**Ethical Analyses**

In general, NPs might approach a situation with ethical considerations in the following manner:

- Gather information.
  - Is this a legal rather than ethical question?
  - Is there a law governing this situation?
  - Consider laws governing:
    - Scope of practice
    - Kickbacks
    - Patient privacy and confidentiality
    - Billing Medicare, Medicaid, and commercial insurers
    - Good Samaritan laws
    - End-of-life issues such as the decision not to resuscitate
  - Who is benefiting from this situation? How?
  - Who is being hurt or could be hurt by this situation? How?
  - Do I have a gut feeling about what is the right or wrong course of action in this situation?
- Am I being swayed by what is beneficial to me or my group?
- What would other ethical practitioners do?
- Does my state board of nursing have any guidance regarding this situation on its website?
- Does my malpractice insurance cover me in this situation?

- Structure a plan.
  - Identify the course of action you would like to take.
  - Identify alternate approaches.
  - Identify the pros and cons of the preferred course of action, as well as the alternative approaches.

- If it is a patient care matter, present the issue to the patient, if appropriate.
- Tell the patient that you would like him or her to direct you in this situation.
- If it is a business matter, consult with your partners, committee members, employer, and/or employees.
- If there is a code of conduct from a governmental agency, a professional society, or your own institution that applies, then follow the dictates of that code.
Make a decision. Prepare, for yourself, an argument that supports your decision. Carry out your plan.

If you decide later that you made the wrong decision, learn from your mistake.

Of course, every situation is different and is accompanied by nuances that are beyond the scope of this text. To explore medical ethics and problem solving, an excellent reference is a recent book by Dr. Bernard Lo.³

Notes


Chapter 17: Strategies for Nurse Practitioners

The difference between making do and advancing is like the difference between eating all of what is put on one’s plate and deciding what to have for dinner. More and more, nurse practitioners (NPs) are planning their own menus. Many still are simply making do with what is put before them. Not everyone knows right out of graduate school that he or she wants to work at stabilizing individuals with heart failure. So sometimes it takes a few job switches to find a niche, but finding a niche is the key to happiness in the profession, in the opinion of the author. One wants to be seen as an expert, not as just a warm body. Ideally, one builds a body of knowledge throughout a career rather than being perpetually a newbie.

The knowledge base to support sound clinical judgment is only one thing NPs need to worry about. There is also the specific workplace culture and the national and regional legal and business landscape to negotiate. NPs faced with restrictive or outdated
laws often report at professional meetings that they are proud of how they are able to function despite the law. For example, NPs who want to own their own businesses but practice in states without full practice authority can construct a private practice that conforms to the law by hiring a physician consultant. NPs practicing in states where the law requires physician oversight to prescribe can do so as long as a physician takes the necessary steps to conform to the state’s requirements. NPs who cannot be designated as providers on payers’ panels may actually perform patient care if a physician is designated as the official provider. In these cases, NPs say their reward is that patients know they are providing their care and appreciate NPs’ efforts.

Although many NPs are making the best of existing law, in many states, the law is still unsatisfactory. The states where NPs are free to practice their profession without mandatory participation by physicians are still in the minority.

**Opportunities in a Changing Field**

In states where barriers to NP practice have been lifted and reimbursement is attainable from third-party payers, there are opportunities for healthcare delivery systems that increase attention to
preventive medicine and access to citizens and provide alternatives to expensive physician-oriented systems.

Under a see-a-nurse-first system, patients initially are seen by a registered nurse or NP. The nurses take care of as many of a patient’s healthcare problems as is prudent, and then seek consultation and referral for those problems that exceed the scope of their practice. **Figure 17-1** depicts a see-a-nurse-first system.

![Figure 17-1 See-a-nurse-first primary care delivery system.](image)

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Opponents of the See-a-Nurse-First System

Physicians often oppose the see-a-nurse-first system of healthcare delivery. The American Academy of Family Physicians (AAFP) issued the following policy regarding NP practice: “The nurse practitioner should not function as an independent health practitioner. The AAFP position is that the nurse practitioner should only function in an integrated practice arrangement under the direction and responsible supervision of a practicing, licensed physician.”¹

Some patients may be suspicious of a see-a-nurse-first system as well. For that reason, patients should be offered a choice of nurse and/or physician providers. Once the law offers a level playing field, both physicians and NPs will have incentives to improve their services to patients and will advance their respective professions.

Challenges for NPs Attempting to Advance the Profession

First, there is the matter of the energy required. NPs may be accustomed to relying on volunteer organizations. It is time to hire professionals. Public relations experts, not volunteers, develop public relations campaigns for physician organizations.
Physicians do not expect to see 30 patients at the office, stop by the hospital on the way home, and then get together at 8:00 p.m. to develop public relations campaigns. Physician organizations hire public relations firms or retain in-house staff whose sole job is to attend to the public image of physicians. NPs can hire professionals, too, and they should. Much publicity can be gained with a small budget and creative public relations professionals.

Second, there is the challenge of publicizing the good in NPs and comparing NP services to physician services without denigrating physicians. The solution to that challenge is to continue to publicize the studies that have shown that NPs are as competent providers of primary care as physicians.

Third, there is the phenomenon that every action generates a reaction. When physicians see NPs step up efforts to advance the profession, they may feel it necessary to react with more aggressive efforts. NPs who are intimidated by this should focus on their goal of advancing the profession to stay on course.
The major focus of physician arguments—that only physicians should have the authority to direct patient care—is the educational differential between NPs and physicians. However, physicians set their own educational level, and there has been no major study of physician education and training since 1910, when Abraham Flexner published a report commissioned by the Carnegie Foundation that called for medical training to be university-affiliated programs rather than 8-month programs to which students came without a high school diploma.² There are no studies showing that the appropriate education for providing primary care is 4 years of medical school and 3 years of residency, which is the education for all physicians, whether they are brain surgeons, researchers into neurotransmitters, or providers of primary care. On the contrary, there are many studies showing that NPs are quite appropriate providers of primary care.

**Strategies to Implement Collectively**

NPs are familiar with the advantages of working collectively toward change. First, individuals can pool money and thus gain more purchasing power than an individual NP. Second, groups are taken more seriously by lawmakers and political parties than are individuals.
Marshaling support of even homogeneous groups is no small accomplishment. In the case of NPs, a stumbling block to collective action is the heterogeneity of NPs, as not every NP has the same professional interests, viewpoints, or goals. For example, NPs who are professors have professional goals that include getting government funding for their educational programs. NPs who are clinicians do not have educational funding as a top-priority goal. Instead, they have the goal of being able to practice with few barriers.

Nevertheless, organizations are necessary for the advancement of the NP profession. NPs inspire, encourage, and rejuvenate other NPs, which is necessary when the goals are long term.

**Ten Organizational Strategies**
The following 10 strategies are suggested for NPs who want to advance the profession and/or their own opportunities.

**Set a Goal**
For example, one NP set herself a goal of becoming a primary care provider (PCP) credentialed by health plans. She built up a base of loyal patients, became an excellent clinician, and worked with the state’s organization of NPs to change the law so
that an NP could be designated by a health maintenance organization (HMO) as a PCP. She succeeded.

Of course, NPs work not only in primary care but also in specialty practices and tertiary care. One NP set the goal of providing preventive cardiology services to cardiology practices. She offered to take over the counseling for patients who were having trouble juggling low-salt diets, side effects of diuretics, and frequent bouts of edema. She succeeded. She worked out of one cardiology practice, but other cardiology practices began to send patients her way. In every setting, NPs need to choose an achievable and reasonable goal, one that affects not only themselves but also other NPs.

**Analyze the Law for Barriers**

There is much ignorance and confusion about the law as it affects NPs. Some NPs say, “The law says we need to be supervised, but we really practice independently.” By participating in a practice situation where the limits of the law are stretched and NPs are involved in work-arounds (work around the law), NPs are taking a risk, and there is no reason for things to change. In some states, the law puts responsibility squarely on the NP for ensuring that supervisory requirements are met. Clinics,
hospitals, and medical groups have little to lose if they provide little or no supervision and let NPs go as far as their desire for intellectual adventure and professional judgment allow. The incentive to let NPs practice without oversight is economic. Many NPs are bringing in at least $180 per hour and getting paid about $60 per hour. If an NP makes few mistakes and no one enforces the law, everything runs smoothly. However, the better an NP does with independent decision making, the more momentum builds for more independence. Pretty soon the NP is out on a limb, taking night calls for cardiovascular surgeons with no physician available to help, much less supervise. As soon as an NP makes a mistake, the burden is back on the NP for not seeking supervision. If the NP is a practice owner making $180 per hour and willing to take a risk, that is one thing, but if the NP is an employee earning $60 per hour, the risk outweighs the benefits.

Some NPs have argued that current law and custom permit them to practice in a satisfying manner, and they ask, “Why open a can of worms by attempting to change the law?” This argument not only offends a sense of legal “neatness,” where law and current practice jibe, but also condones a timidity that is incongruent with the level of assertion needed to perform as an NP. Why would NPs participate in
life-and-death decisions for patients and yet retreat from challenging statutory omissions that relegate NPs to the invisible category of “others” or “nonphysicians”?

Every NP needs a copy of every law that affects his or her practice. That includes law that does not mention NPs but that affects NPs because of the omissions. For example, every NP needs a copy of the NP scope of practice in the state where he or she is licensed and practicing.

National NP organizations need fact sheets that cover federal law regarding:

- Delegation of duties in nursing home care
- Direction of the care of hospitalized patients
- Anti-kickback laws
- Definition of medical care and medical care provider
- Application for Drug Enforcement Administration numbers
- Reimbursement by Medicare and Medicaid
- Coding and billing of Medicare and Medicaid visits
- Documentation guidelines
- Definition of collaboration
Because the officers and board members of NP organizations change from year to year, NP organizations should maintain a current file of the relevant law for each new officer to review at the start of the term. Much anxiety will be avoided if NPs have copies of the exact language of the law.

**Lobby for Eradication of the Barriers**

Once the barriers are known, organizations can enlist lobbyists to help eradicate them. NPs may make progress in one area, such as convincing the federal government to allow NPs to be patients’ medical home only to find that there is some phrase in state law that a state administrator interprets as barring NPs from that role.

NPs should not expect to win passage of new legislation the first time it is introduced. Each time an issue is lobbied, more information comes out about NPs, and the idea of NPs becomes more familiar and palatable to lawmakers.

NPs may argue that if certain issues are brought up, they may lose ground in the law rather than gain it. NPs ask, “What if we introduce a law, but it is amended and passed at the last minute and we end up losing ground?” While that is a possibility, it is not
probable. Compare a situation an NP faces every day in clinical practice: A patient arrives complaining of low back pain. In 99% of cases, the back pain is caused by musculoskeletal strain and will respond to rest and nonsteroidal anti-inflammatory drugs. In one case out of 100, the back pain will be something else, and in a very minuscule percentage of cases, the low back pain will be cancer. Does the NP rush all patients who complain of low back pain to magnetic resonance imaging at the first visit? No. Likewise, the chance that NPs, by introducing legislation to advance the profession, will actually lose ground is minuscule, for the following reasons. First, NPs are valuable to medical groups, hospitals, HMOs, and health departments. Second, a good lobbyist, as well as a sponsor of a bill, will follow it very closely. It is unlikely that a bill that was introduced on behalf of NPs will be amended without the knowledge of the NPs’ lobbyist. Because the lobbyist is hired by an NP organization, it is unlikely that a lobbyist will be caught unaware or will fail to rally the NP organization client when necessary. Third, there is virtually no opposition to NPs as healthcare providers other than from organized physician groups, and then only when NPs are striving to release the legal apron strings that tie NPs to physicians. NPs should not be deterred by the prospect of introducing a bill five
times before it is passed. If it takes 5 years to get a bill passed, so be it.

**Sell MCOs and Purchasers of Health Services on NPs as Providers**

NPs can offer managed-care organizations (MCOs) and employers who purchase healthcare services for their employees quality services at a reasonable cost. However, NPs cannot depend on health plan purchasers to know what NPs can do unless NPs educate them.

MCOs and business executives are used to listening to business presentations from those who want to sell services. NPs may not be used to giving business presentations, but they can learn. Alternatively, NP organizations can retain the services of professionals who make business presentations to do the work on their behalf.

The basic message of a business presentation on why MCOs and businesses should contract with NPs as providers is that NPs give high-quality care at a reasonable price. The message should be supported by data demonstrating the quality of NP care and numbers demonstrating the rationale of the pricing schedule. Finally, MCOs and businesses
need to know how they can contract with NPs, that is, where the NPs are located and whom to contact.

**Promote NPs to the Public**
For the most part, individuals who have experienced the care of an NP have been satisfied. However, there is still too great a number of people who have never experienced the care of NPs. Promotional efforts need to be aimed at the unconvinced segment of the population.

Further, some individuals who have experienced the care of NPs and been satisfied may not know that NPs are responsible for the care they provide. People may believe that NPs only relay what a physician has decided and that they are simply physician helpers. NPs need to establish themselves as experts. After NPs spend the time to actually become experts, they can advertise their expertise through newspaper articles in which NPs give advice on healthcare topics, talk radio, television public service announcements, paid advertising, presentations at community events, journal articles, podcasts and video blogs, and one-on-one interactions between NPs and patients.

**Work the Data**
All studies done on the care given by NPs are supportive of NPs. These studies include many studies done by physicians and operations researchers as well as studies done by nurses. NPs need to cite and recite the data in language that a layperson can understand. NPs also need to compile their own data on the effectiveness of their care. For example, electronic medical records systems now allow clinicians who treat diabetes to produce data that compare the effectiveness of individual clinicians at controlling patients’ HbA1c. While physicians are hashing and rehashing the educational differences between NPs and physicians, NPs need to be repeating the data that support the assertion that NPs give good care. Therefore, the educational differential, while significant, must not be relevant. As mentioned earlier, to date, physicians have no data to prove that their additional years of education make them better PCPs than NPs.

Hire Professionals to Do the Association’s Work

It is time to hire professionals and for NP associations to act like businesses. It is time for board members to be relieved of the hands-on “doing” of association business so they can do what board members are supposed to do: decide how the
association money is spent and evaluate the performance of the hired help. Many NP associations have done this.

Why? Because NPs are operating in an industry where changes are coming quickly. NPs stand to gain ground, but progress will not come easily. Other professional groups are spending large sums to have experts monitor changes and ensure that their members’ interests are represented when policy is made, law is enacted, and contracts are signed.

NPs have great potential because they combine nursing and medical knowledge. In volatile times, there are great opportunities. However, no laws will be enacted that designate NPs as PCPs or other types of providers unless bills are drafted expertly, hard lobbying is done successfully, and public relations efforts are increased and well targeted. No state regulations will be changed in NPs’ favor without carefully drafted, persistent requests to state agencies. No health plans will open themselves to additional providers unless they can be shown how doing so will benefit them.

How are NP organizations going to fund all this expert help? By developing revenue streams other
than membership dues. Each NP organization that does not have an annual continuing education conference for which the registration fee is at least $175 per day should work on creating one. Putting on a conference may require hiring a part-time conference coordinator. The budget for a conference should support a conference coordinator, the speakers’ time, and the expenses of room rental and coffee, and the conference should make a profit. Each organization should charge for the use of its name and directory. When files of laws are sent out on request, the organization should charge for that service.

NP organizations need public relations specialists, lobbyists, and attorneys either on retainer or a per-project basis. Each organization also needs a paid executive director who answers to the board of directors.

At a time when NPs are defending themselves in the press and to the legislatures and fighting for their spot in the managed-care landscape, they need to hire expert assistance, not rely on do-it-yourself operations.

Do Not Be Timid
Nurses, as a group, have lacked confidence and assertiveness in the past. NPs are trying to overcome barriers that were erected long before their title and position existed, barriers that resulted from this history of timidity in nursing. For example, in 1955, the American Nurses Association’s (ANA’s) model definition of nursing stated that nursing “shall not be deemed to include any acts of diagnosis or prescription of therapeutic or corrective measures.”

In 1955, however, nurses were already performing acts that clearly were within the definition of diagnosis and prescription of corrective measures. Nevertheless, by 1967, 22 states had incorporated the ANA model language into state law. To cover hospitals and agencies where nurses were engaging in “acts of diagnosis or prescription of therapeutic measures,” joint statements of hospital, medical, and nursing associations were written that allowed nurses to perform certain acts, such as venipuncture or initiating intravenous fluids. The joint statements were at odds with the law, yet no one challenged the law or the policy statements.

Today, experienced NPs find that they can practice independently, meaning that they make decisions about patient care without consulting physicians. However, if state and federal regulations call for collaboration and define collaboration as
supervision, NPs who push the envelope without also pushing for changes in legal language that supports their independent practice will be going nowhere.

It is time for NPs to affirm that NPs are experts in primary care. They should make statements such as “I am an expert in managing diabetes” rather than “NPs do primary care in collaboration with physicians.”

**Erase Collaboration from the Legal Vocabulary**

NPs, like other healthcare providers, cannot function without collaboration with other experts. Nevertheless, nurses are virtually the only profession that has collaboration as a legal mandate.

NPs have considered the word “collaboration” an improvement on the word “supervision.” However, a close reading of federal law reveals that the law defines collaboration as supervision.

When arguing for erasure of barriers to NP practice, NPs have had difficulty convincing legislators of the difference between collaboration and supervision, and with good reason. Although there is a difference
in the definitions of the two words—the dictionary defines collaboration as “work jointly with others” (and alternatively as “cooperate with or willingly assist an enemy force occupying one’s country”)\(^6\) and supervision as “superintend, oversee”\(^7\)—a legal mandate to collaborate suggests that the group given the mandate is not the final authority on a matter. Although NPs are not so arrogant as to consider themselves final authorities on all matters of health care, certainly experienced NPs can and should consider themselves final authorities on primary care and other areas of medicine where they have specialized and have extensive education and experience. Consultation is appropriate, but a legal requirement for collaboration is not.

**Insist Upon Legal Clarity of NP Authority to Practice**

Compare Laws A and B on NP scope of practice:

**Law A:**

The board recognizes advanced and specialized acts of nursing practice as those described in the scope of practice statements for nurse practitioners certified by national
certifying bodies recognized by the board.

*Citation: Alaska Admin. Code* tit. 12, § 44.430.

**Law B:**

The nurse practitioner provides holistic health care to individuals, families, and groups across the life span in a variety of settings, including hospitals, long-term care facilities, and community-based settings. Within his or her specialty, the nurse practitioner is responsible for managing health problems encountered by the client and is accountable for health outcomes. This process includes:

a. Assessment  
b. Diagnosis  
c. Development of a plan  
d. Intervention  
e. Evaluation

The nurse practitioner is independently responsible and
accountable for the continuous and comprehensive management of a broad range of health care, which may include:

a. Promotion and maintenance of health
b. Prevention of illness and disability
c. Assessment of clients, synthesis and analysis of data, and application of nursing principles and therapeutic modalities
d. Management of health care during acute and chronic phases of illness
e. Admission of his/her clients to hospitals and long-term care facilities and management of client care in these facilities
f. Counseling
g. Consultation and/or collaboration with other care providers and community resources
h. Referral to other healthcare providers and community
resources
i. Management and coordination of care
j. Use of research skills
k. Diagnosis of health/illness status
l. Prescribing, dispensing and administration of therapeutic devices and measures including legend drugs and controlled substances . . . consistent with the definition of the practitioner’s specialty category and scope of practice . . .

The nurse practitioner is responsible for recognizing limits of knowledge and experience, and for resolving situations beyond his/her nurse practitioner expertise by consulting with or referring clients to other healthcare providers. The nurse practitioner will only provide healthcare services within the nurse practitioner’s scope of practice for which he/she is educationally prepared and for which competency has been established and maintained.
Educational preparation includes academic course work, workshops or seminars, provided both theory and clinical experience are included.

_Citation:_ OR. _ADMIN. R. § 851-050-0005.

There is no question about what an NP in Law B can do. Many questions are left unanswered by Law A, however; for example, what is “advanced and specialized acts of nursing practice?” Do such acts include medical services, or is an advanced practice nurse the same as a registered nurse? While Law B is specific and permissive of NP practice, Law A is unclear.

NPs need to insist on clarity. Without clarity, other groups may decide what the law addressing NPs means.

**Notes**


Chapter 18: Frequently Asked Questions from Nurse Practioners

**Question:** Can I/should I take a job that includes evaluation and management of hospitalized patients if I am a family nurse practitioner (FNP), an adult nurse practitioner (ANP), a primary care pediatric nurse practitioner (PNP), or a gerontological nurse practitioner (GNP)?

**Answer:** Nurse practitioners (NPs), especially those who are new graduates, are being offered positions with specialty practices. Often, these positions require the NP to see hospitalized patients; for example, a neurology practice wanted a newly graduated FNP to see patients in the office but also to go to the hospital to evaluate individuals with possible stroke. A cardiology practice wanted an FNP to conduct office visits but also to go to the hospital when there is a patient with suspected myocardial infarction.
The new graduate asked the employer, “Who will help me learn the acute care side of the job?” The employer said, “Don’t worry about it.” That answer perhaps indicates that the employer either can’t find an NP certified in acute care or doesn’t know that FNP education is focused on primary care. Other than the NP’s making a mistake, the employer has minimal risk. It’s the NP who is taking a risk by taking a job for which he or she is unqualified. The risks include discipline by a board of nursing, payer refusal to reimburse for services, and malpractice charges.

In the author’s opinion, the answer to the question “Can I/should I take a job that includes evaluation and management of hospitalized patients if I am an FNP, an ANP, a PNP or a GNP?” is no, but it doesn’t really matter what an individual attorney thinks. Only the state board of nursing has the authority to make that determination. Some boards of nursing would agree that an FNP should not be working in acute care, and other boards may allow an FNP to perform acute care or to do so under certain circumstances (such as providing only primary care within the acute care setting or managing only those patients who are in unmonitored beds).
There is an additional important consideration even if a board of nursing allows FNPs under its jurisdiction to perform acute care. If something goes wrong, the first thing the plaintiff’s attorney will do is attack the credentials of the FNP. Ask yourself this question: Am I prepared to argue, if challenged, that I’m prepared, educationally and experientially, to provide acute care?

Some FNPs have been working in acute care for years. Acute care certification is relatively new, and for many years, there was a demand for NPs to cover hospitalized patients, but there was no certification in acute care. So the only option was to hire an FNP, an ANP, or a PNP. Some highly experienced NPs who provide acute care are FNPs; that is, they were hired before the acute care certification was available and, after many years of managing hospitalized patients, are very experienced and capable. There is less reason for those individuals to be concerned. If they were asked how they are educationally and experientially prepared, they would point to their 20 years of experience and 20 years of continuing education in the care of hospitalized patients.

For guidance on this issue, check with your state board of nursing. Employers have no authority
regarding NP qualifications and often are uninformed. It is the practitioner’s responsibility to be appropriately prepared and credentialed for any specific job.

**Question:** I am worried about the quality of care in the practice where I work. What should I do?

**Answer:** NPs sometimes find themselves in a working environment where, for whatever reason, patient care is substandard. Nurses are told in nursing school to be change agents and patient advocates. So the NP’s instinct is to try to fix the problem. Not everyone wants to be fixed, though. Sometimes, an NP stirs the workplace pot enough that someone becomes annoyed and the NP is fired. Now, the NP feels wronged because he or she was just trying to fix things. In spite of good intentions, the NP now has “terminated” on his or her record. The NP wants to speak to an attorney.

For the most part, there is no legal remedy once an employee is fired. An employer can fire an employee with or without a reason. The only prohibitions on firings are based on age, gender, race, or religious or sexual preference. In a very few cases, the NP could be a whistleblower and receive a damage award after filing suit against the
employer and claiming he or she was fired for complaining about a patient safety issue. The rules for qualifying as a whistleblower are very complicated, and most fired healthcare providers won’t meet the criteria. And “quality of care” can be subjective; clinicians don’t always agree on what it is. So NPs will want to check on the evidence before judging someone else’s care.

If unsure about how to bring up a quality-of-care issue, seek advice from colleagues, books, and articles. There are many books and articles on how to deal with uncomfortable situations and relationships at work and many guidelines on generally accepted standards of treatment and care. There are coaches who can help with this. Enlist consultation, whether from books or experts, before speaking up, or be prepared to find another job where the philosophy of care is similar to your own; then consider reporting the low-quality clinician, practice, or facility to the appropriate regulatory agency.

**Question:** I am worried about the way the medical assistant in our office gives out telephone advice. I heard him tell a patient not to worry about the symptom the patient was calling about. It seems to me that this would be a form of diagnosing, which is
the practice of medicine. Boards of nursing come down hard on nurses who exceed their scope of practice. What about a medical assistant’s scope of practice? Am I in any way liable if the medical assistant gives out erroneous information and someone is harmed?

Answer: There are two legal issues here—liability for malpractice and exceeding scope of practice. If a medical assistant negligently or incompetently advises a patient and the patient suffers an injury because he or she relied on the advice, the medical assistant and his or her employer could be sued. It is unlikely that a nurse or an NP working at a practice would be sued if the nurse or NP doesn’t employ or supervise the medical assistant. However, if a nurse or NP had supervisory responsibilities, then it is possible that the nurse or NP would be named as a codefendant. It is the responsibility of the employer of the medical assistant to monitor the medical assistant and make sure he or she is acting within the standard of care and scope of practice. Laws differ significantly from state to state on scope of practice of medical assistants and who can supervise them. Check your state’s law on a nurse’s supervisory responsibilities for medical assistants. Some states certify some forms of medical assistants, and in those states,
medical assistant practice is regulated. In other states, there is minimal oversight of medical assistants.

**Question:** Is it a Health Insurance Portability and Accountability Act (HIPAA) violation to leave biopsy results in a voice-mail message?

**Answer:** It could be. If a clinician has asked the patient “How would you like me to communicate the results?” and the patient says “Leave it on my voice mail,” then it would not violate HIPPA to do so. Unless the patient has directed the clinician to leave the results on the voice mail, the clinician cannot assume that the voice mail is private and restricted to that individual. Certainly, it could be a shock to an uninformed family member to check the household’s voice mail and find that a loved one’s biopsy was positive. One can assume that patients don’t want their diagnoses communicated in that manner.

Under federal privacy laws, protected health information is defined as individually identifiable health information transmitted or maintained in any form or medium. Individually identifiable information includes diagnoses, procedures done and the results, name, address, birth date, and other identifying numbers.
Ideally, any time a clinician orders a test, the clinician will ask the patient to agree to a means of communicating the results. One way to cover HIPAA bases is to get each patient to authorize, in writing, specified disclosures in specified ways. All practices should have an authorization form handy and use it with every patient.

If the practice or facility does not have one of these forms filled out and signed and does not have the patient’s authorization to leave the results on voice mail, then leave this message: “This is [your name] at [your office or facility]. Please call me at [number].” Under certain circumstances, even this is too much information. If the office is a sexually transmitted disease clinic, Planned Parenthood, or even a plastic surgery office or some other emotionally sensitive medical office, it is best to say the message is from “the healthcare practice” or “the clinic.”

**Question:** Does a subpoena mean an NP must release a patient’s record?

**Answer:** NPs ask whether they are obligated to release all or part of a patient’s medical record when they receive a subpoena for records. Sometimes,
the subpoena warns that the recipient must comply or face penalties.

First, there is a difference between a subpoena issued by a judge and a subpoena issued by an attorney. A *subpoena duces tecum* is simply an attorney’s request for documents. To release records in response to an attorney’s subpoena, without obtaining the patient’s authorization, can result in a civil suit by the patient or disciplinary action by the state licensing board. So get the patient’s consent before releasing any records.

However, if the request comes from a medical or nursing licensing board, the clinician must release the records. The patient’s consent is not required.

If a subpoena is signed by a judge or hearing officer, then the clinician is permitted, under HIPAA, to respond by sending records, or the clinician can respond to the request but not necessarily send the records. The clinician can ask to quash the subpoena or narrow the request if there are good reasons for doing so.

If the practice or facility has a privacy officer—and that should be the case—then the clinician should give the subpoena to the privacy officer for handling.
Question: If a clinician sees a patient in the morning and again in the afternoon for a new or worsened condition, how is the second visit billed?

Answer: One of the Medicare Administrative Contractors answered this question on the company’s website as a frequently asked question:

[We] would not expect to see two evaluation and management (E/M) services reported on the same date on a routine basis. A second E/M service would be billed for rare circumstances only. If a second E/M service is required on the same date of service, the documentation should clearly provide evidence that the second E/M service occurred, the reason for the additional E/M service, and documentation of the medical necessity of the second E/M service. If a second E/M service is reported on the same date, the service could initially be denied. The denial can be appealed using the appeal guidelines.

The Medicare Administrative Contractor websites are a great source of information on billing and
coding. NPs who see patients covered by Medicare should find out who their local contractor is (e.g., Noridian, Novitas, or WPS) and peruse the website, looking at the educational offerings and the frequently asked questions. Sign up for email updates.

**Question:** How can an advanced practice nurse, a physician, or a physician assistant bill patient teaching?

**Answer:** When a clinician spends more than half of his or her time counseling a patient during a face-to-face visit, the clinician may bill an evaluation and management code, based on the time spent. Counseling includes medically necessary discussion about

- lab results, prognosis, or treatment options;
- instructions for treatment;
- importance of compliance; and
- reduction of risk factors.

For example, if an NP spends 40 minutes with the patient in the office and 22 minutes of that time is spent in discussing lab results and treatment options, the NP may bill the highest level office visit. See the current edition of Current Procedural Terminology (CPT) for the times that correspond
with each CPT code for evaluation and management.

Document the time spent face-to-face, the necessity for the discussion, and a summary of what was discussed. The clinician could document history, examination, and medical decision making as well, but it is the time spent that determines the choice of code when billing a counseling visit.

**Question:** How soon after seeing a patient must a clinician complete the medical record documentation?

**Answer:** Ideally, records are completed—written and signed—shortly after the patient has been seen, but at the latest, the records should be completed and signed within 2 days of the service. This time frame comes from a Q&A on a Medicare Administrative Contractor’s website.

Medicare can’t be billed until the record has been completed. The agency says 2 days might be necessary if the clinician dictates, to allow for transcription and verification before signing.

**Question:** A patient keeps coming to me asking for a controlled drug with street value, and I can find no
legitimate reason to prescribe it. The patient gets belligerent with me when I decline to prescribe what he wants. I want to terminate my clinical relationship with the patient and never see him again. How should I handle this situation?

Answer: There are five bases that you need to cover:

1. If the patient has been assigned to you or your practice by a health plan, the plan may require you to go through a specific process to transfer care. Read the contract between the patient’s health plan and the practice to determine whether you may discharge him and, if so, what notice or other paperwork must be filed.

2. Write the patient a letter, stating the following:
   - You are terminating the patient–provider relationship 30 days from the date of the letter.
   - You will provide services for an acute or chronic illness until the stated date.
   - The patient’s record will be sent to another clinician on request.

File a copy of the letter in the patient’s chart. Send the letter certified, return receipt requested. If the patient refuses the letter, file
the unopened envelope in the patient’s chart and send another letter via regular mail. (Some individuals are wary of certified mail and will always refuse it.) Note in the patient’s chart that a second letter was sent, the method of delivery, and the name of the sender.

You need not state the reasons for discharging the patient, but you may want to. You need not provide names of other healthcare providers nor find an alternate provider.

3. Search the state board of nursing website to ascertain that you are not “abandoning” the patient under any definition or rules of the board. (If you cover the bases listed here, that should not be a problem.)

4. Do not discharge a patient because of the patient’s age, race, nationality, disability, or handicap unless your education and training clearly disqualify you from caring for such a patient. To terminate a patient for any of these reasons could be a basis for a civil rights lawsuit based on discrimination.

5. Do not terminate a relationship with a patient who is in an acute episode of illness; for example, if a patient is hospitalized, it is not the time to fire the patient. Also, hospital
emergency departments are restricted by federal law from refusing to treat patients.

**Question:** May a clinician, whether a primary care provider, psychiatric/mental health nurse practitioner, psychiatrist, or school nurse, contact a patient’s family or law enforcement if the clinician believes the patient might hurt himself or herself or others?

**Answer:** Generally, communications between healthcare providers and patients are private and confidential, and the patient must authorize disclosures unless those disclosures are for treatment or payment purposes or healthcare operations. Psychotherapy notes have special protections. However, in light of recent mass murders by patients who have been under psychiatric care and have voiced their intention to harm others, the government has carved out new exceptions to the privacy laws. A California Supreme Court case from 1976 (*Tarasoff v. University of California Board of Regents*) set precedent that a mental health clinician must protect an individual who is the target of serious and imminent threat of harm by notifying the targeted individual and law enforcement of the patient’s threats.
So, yes, a clinician may breach the patient privacy and confidentiality principles if the threat of harm to the patient or another individual is serious and imminent. Federal regulations governing patient privacy have an exception for a patient who presents a serious and imminent danger. If a provider, in his or her professional opinion, reasonably believes that a patient presents a serious and imminent threat to self or others, the provider may reveal necessary information to law enforcement, school officials, family, or other persons in a position to protect the patient or another. The clinician may (and should) alert an individual whom the patient has threatened to harm if the threat is serious and imminent.

**Question:** Are NPs required to report employers’ billing errors? NPs often ask whether they will be held responsible if their employer bills Medicare or another third-party payer incorrectly. For example, if an employer bills Medicare under its own provider number for visits conducted by an NP and does not follow the rules on incident-to billing, can the government hold the NP liable?

**Answer:** The federal government would say yes. On February 8, 2012, the Office of Inspector General (OIG) of the U.S. Department of Health and
Human Services (HHS) issued an alert (OIG Alert) directed to physicians and cautioning against the risks inherent in reassignment of their rights to receive Medicare payment for the services or items they furnish to Medicare patients. The Alert does not mention NPs specifically or specific billing issues applicable to NPs, but one can assume that the government’s approach to the case that inspired the Alert would apply to NPs, that the government expects NPs to take an active part in making sure that the claims for their services are filed correctly, and that the government expects clinicians to report billing irregularities even though an employer, not the clinician, is doing the billing.

**Question:** *If I am covered with malpractice insurance by my employer, do I need to be named on the policy?*

**Answer:** Insurance policy language can be tricky. When an NP is covered under an employer’s malpractice insurance policy, it is important for the NP to be sure that he or she is a “named insured.” One would find the list of named insureds on the declarations page of the policy.

Here is why this is important. In a case —*Connecticut Med. Ins. Co. v. Kulikowski* (942 A.2d
334 (2008)—an NP was referred to by job title but not named on the declarations page of her employer’s malpractice policy. Both the NP and employer (a physician) were sued. The parties settled with the plaintiff for over $1 million. The insurer paid the plaintiff $1 million. The plaintiff (the injured patient’s family) sued the insurer, arguing that the defendants were covered for $2 million—$1 million per provider. The trial court held that the named insured—the physician—was covered for $1 million and, if the NP had been named as insured, she would have been covered for another $1 million, but because she was not named, any coverage for her would be included under the $1 million for the physician.

This case means that in the settlement between patient and clinicians, any amount over the $1 million paid by the insurance company on behalf of the named physician would need to come from the clinicians. This case tells us that the best coverage for an NP who is covered under an employer’s policy is when the NP is a named insured.

A safe alternative would be for the NP to purchase his or her own policy.
**Question:** When does a newly hired NP become profitable to a practice?

**Answer:** An employer’s income may drop for about 6 months after a solo physician or practice hires a new NP, because the practice will be paying the NP’s salary, benefits, and overhead and yet the new NP may not have a large enough patient load to cover salary, benefits, and profit for the practice. But after 6 months, the practice should reach the break-even point. After 12 months, the practice should have recouped the losses of the first 6 months, and during the 2nd year of the NP’s employment, the practice should be making a profit attributable to the NP’s efforts.

Should the practice hire a physician rather than an NP, the practice should expect to count on 9 months of losses, simply because physicians’ salaries and benefits usually are greater than those of an NP and a new physician is not likely to be as efficient as an experienced physician nor carry a full patient load. Nevertheless, physicians who hire new physician associates usually recoup their losses and are making a profit from the associate’s work by the 2nd year of employment.
Question: Am I at risk of being charged with participating in a “pill mill” (a practice that gives out prescriptions for controlled drugs without appropriate evaluation and management) if I am prescribing opioids appropriately but some of my colleagues at my practice aren’t following the guidelines? I am aware that governmental agencies are focusing on practices that prescribe opioids without medical justification and appropriate monitoring. Sometimes, a colleague is away, and I am required to refill controlled drug prescriptions. Sometimes, I don’t agree with the plan of care.

Answer: You are at risk, but there are several ways to decrease that risk. One way is for each clinician to cover his or her patient refills as much as possible before the clinician leaves for time off. Another way is for clinicians in group practices to agree on the standards to be followed in the practice and to follow those standards. Another way is to contract with patients who are being prescribed opioids so they agree they will give the office 72 hours’ notice when they need a refill, to avoid having them come in when their primary provider is off. Finally, if you must prescribe opioids for another clinician’s patient, prescribe the smallest amount that will cover the patient until the primary provider returns.
When a practice is “busted” by law enforcement, for suspicion of being a pill mill, it is likely that all of the prescribing practitioners will be investigated and reported to their state licensing agency as well as to the Drug Enforcement Administration. An NP who is caught up in a pill mill investigation will be presumed to be part of a plan to sell drugs or prescriptions or, at minimum, to have reckless disregard for the standard of care. An NP who has been prescribing appropriately may have a sound defense but will nevertheless need to retain an attorney and present that defense.

If an individual finds himself or herself working in a practice that prescribes opioids for many or all of the patients, the NP should consider reducing his or her risk to license and career and finding employment elsewhere.

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• Note: Page numbers followed by t indicate material in tables.

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