For all the progress states are making and have made in the quest for nurse practitioners to practice to their full education and training, it is apparent that even most states with supposed “full practice authority” still face enormous, arbitrary barriers.

One of the most significant of these barriers is at the federal level and involves Medicare reimbursement in what is a two-tiered system.

**Reimbursement.** Today, a nurse practitioner billing Medicare under their own national provider number (NPI) will receive only 85% reimbursement, as opposed to 100% reimbursement for physicians. The last time this issue was federally addressed was in the Balanced Budget Act of 1997 (Frakes & Evans, 2006). Prior to this, nurse practitioners were first reimbursed in 1990 at 85% but only when working in rural settings, and skilled nursing facilities (WOCN, 2012). The change to include nurse practitioners in all settings with the Balanced Budget Act of 1997 was significant. However, it has been 27 years that nurse practitioners are reimbursed by Medicare at 85% with no signs of that changing.

It should be noted that this is with nurse practitioners meeting or exceeding today’s quality measures. Further, the CMS Manual System, 100-02 of the Medicare Benefit Policy (2007) states the following:

D. Collaboration: Collaboration is a process in which an NP works with one or more physicians (MD/DO) to deliver health care services, with medical direction and appropriate supervision as required by the law of the State in which the services are furnished. In the absence of State law governing collaboration, collaboration is to be evidenced by NPs documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice [emphasis added]. The collaborating physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient who is seen by the NP.

Of particular note is the bolded area. Technically, even in states with seemingly “full practice authority,” a nurse practitioner must maintain “documentation” and indicate “relationships” with physicians, or would otherwise be subject to Medicare fraud sanctions.

**Home Health Care.** Another Federal area of considerable concern is a nurse practitioner’s inability to order home health care for Medicare beneficiaries. Bills have been introduced in the 2011 and 2013 Congress in both the House of Representatives and Senate, called the Home Health Care Planning Improvement Act (H.R. 2504/S. 1332). The H.R. version has 147 co-sponsors (out of 435 total members) and the Senate has 23 (out of 100). The bill sits in the Subcommittee of Health in the House of Representatives and in Committee of Finance in the Senate. (Library of Congress, 2014). There has been no action in either House since the bill was introduced in June 2013 despite a growing list of co-sponsors. It should be carefully noted that the current session of Congress effectively ends at the end of 2014 and if no action is taken, the process will need to start all over next year.

**Durable Medical Equipment (DME) Face-to-Face Requirement.** There is currently a delay in the enforcement of the DME Face-to-Face requirements. According to CMS (2014), “The law requires that a physician must document that a physician, nurse practitioner, physician assistant or clinical nurse specialist has had a face-to-face encounter with the patient.” The physician must document that a face-to-face was performed. A nurse-practitioner can perform the face-to-face but it needs to be documented by a physician. When referring to durable medical equipment, this includes items like blood glucose monitors, crutches, walkers, and wheelchairs. A single-house bill was introduced, H.R. 3833, to modify the Medicare durable medical equipment face-to-face encounter documentation requirement (Library of Congress, 2014). This Bill has almost no chance of passing this year since it only is submitted in one house and has 23 co-sponsors. Nonetheless, we still await to learn if/when CMS will enforce this rule which has been delayed indefinitely.

**Federal Employees’ Compensation Act** (also known as “worker’s comp”). Nurse Practitioners are not included on the approved list of providers for federal employees to treat work-related injuries. Incidentally, New York nurse practitioners are also excluded on the approved provider list for non-Federal workers in New York State.

These are examples of some major barriers that nurse practitioners face every day regardless of the “color” of their state. The leaders of the Nurse Practitioner Association New York State, the professional association for nurse practitioners in New York State, receive feedback from members concerning all of these issues and seek engaging
stakeholders to work with any individual or organization that can gain traction at the federal level (S. Ferrara, personal communication, August 1, 2014).

With regard to individual states, 2014 has seen tremendous forward progress for nurse practitioner laws and regulations. States with significant movement include, Connecticut, Kentucky, Minnesota, and New York with passage of our Nurse Practitioners Modernization Act. This is largely attributed to the tireless work that each state’s NP association and members do every day. Remember, the state in which you reside determines the rules and regulations of licensure. However, many differences still exist throughout the States in NP practice.

**Alaska:** In Alaska, a “consultation and referral plan” must be submitted to the Alaska State Board of Nursing by the Nurse Practitioner. This includes providing a description of one’s practice, consultation and referral plan, and a quality assurance plan (Alaska State Board of Nursing, 2014).

**Arizona:** The following question was posed to the Arizona State Board of Nursing (2013):

Is it within the scope of practice for an APRN to practice without physician supervision?

YES. Arizona does not require APRNs to be supervised by a physician and may practice independently in Arizona. However, the Nurse Practice Act does require APRNs to collaborate with a physician or other health care provider as needed [emphasis added]. R4-19-5087(A) states that a 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.

**Colorado:** In Colorado, an “Articulated Plan” must be developed with a physician in order to have full prescriptive ability. According to the Colorado Code of Regulations, 4.1. To obtain Full Prescriptive Authority, the RXN-P must develop an Articulated Plan for safe prescribing within five (5) years after Provisional Prescriptive Authority is granted. The RXN-P’s current Physician Mentor and RXN Mentor, if applicable, are required to provide a one-time signature on the Articulated Plan to verify that the RXN-P has developed the plan for safe prescribing in accordance with these Rules.

4.2. The Articulated Plan shall contain the following elements:

4.2.1. Is in writing and is signed by the RXN-P and all mentors at the time of initial development.

4.2.2. Documents a mechanism for consultation or collaboration with physicians and other appropriate health care providers and a mechanism for referral, when appropriate, to physicians and other appropriate health care providers for issues regarding prescribing. (2010)

Regarding Consultation and Referral Plans, “Articulated Plans,” and in the case of New York, “collaborative relationships” – these “plans,” or “relationships” are consistent with nurse practitioner training and education, operationalizing that which every nurse practitioner learns in school — “know when to consult; know when to refer.” It should be noted that the American Association of Nurse Practitioners (2014) and the National Council for State Boards of Nursing (2014) have arbitrarily interpreted the first 3 states mentioned (Alaska, Arizona, and Colorado) as “full practice authority” and “independent” respectively.

While every legislative success deserves accolades and celebration, it is apparent that nowhere in the United States are nurse practitioners truly practicing to the full extent of our training and education. There remains much work to do, particularly at the national level, specifically relating to reimbursement, home health care, DME, and Workers’ Compensation.

**References**


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MEMBER SPOTLIGHT

Alice Caton, FNP-C
Chapter: Capital

Alice Caton graduated from Maria College in Albany as a RN and then the Albany Medical College Nurse Practitioner Program in 1982 as a FNP and became ANCC certified as a FNP the same year. She has since served both her patients and the NP community tirelessly. She has been an educator (Russell Sage college adjunct professor), a preceptor (SUNYIT) and a mentor to many NP students and new NPs during her career. She served as treasurer of the Nurse Practitioner Association PAC, the Nurse Practitioners of New York State Political Action Committee for 10 years. She was involved in the Capital Chapter leadership and assisted with By-Laws revisions for The NPA.

As a RN she was the Assistant Head Nurse in Labor and Delivery at Albany Medical Center Hospital until leaving the position in 1982 to be an Obstetric Nurse Clinician at Albany Medical College. She has been with Seaton Health Internal Medicine as a FNP since 1994.

She has served on the Medical Staff of St. Mary’s Hospital since 1994 including the Policy Committee and been an adjunct professor at Russell Sage College.

Alice has volunteered at the Roarke Center, a walk–in clinic in Troy, NY that serves those without health insurance and the underserved in the community.

In recognition of her long years of exemplary service and professionalism Alice was named NPA Capital Chapter 2013 NP of the Year.

WHY DID YOU JOIN THE NPA?

I joined The NPA (then the Coalition of Nurse Practitioners) in 1982 because I was so delighted and proud to be a part of a health care profession dedicated to helping people get well and then keeping them well.

I have always known there is strength in numbers and to get us recognized as primary players in health care we all needed to have a role and that was through our association. The term “medical home” is not new to us as nurse practitioners - it’s our mantra. Now the health care system knows who we are and this has been because of organizations like ours. What seems like so long ago that we needed to advocate for ourselves and our profession has not changed. I did and still do believe every NP who works in NYS should belong to and support our The Nurse Practitioner Association New York State.

WHAT ARE SOME OF YOUR HOBBIES/INTERESTS?

I’m blessed to be able to travel to many parts of the world, and have three of the best children with spouses, and the gift for having those children - 7 incredible grandchildren. Soon I’ll be a great grandma and I have a partner who loves me and puts up with all my activities.