

Federal Trade Commission
Office of the Secretary, Room H-113 (Annex X)
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Washington, DC 20580

CarsonCompany Comments on Health Care Workshop, Project No. P13-1207

Thank you for the opportunity to submit comments. CarsonCompany LLC is a policy and advocacy consultancy and social media corporation. We advocate on behalf of nurses on issues related to practice. Our principal, Winifred Carson-Smith – has worked with nurses on advanced practice nursing (APN) issues for over three decades; and was the first person to testify before the Federal Trade Commission (FTC) on barriers to practice. Today we submit comments on two concerns:

1. The inappropriate and over utilized “mandatory collaboration” clause included in most advanced practice legislation; and
2. Barriers to competition promulgated and used by various federal agencies.

Advanced practice registered nurses (APRNs) have the unique potential to impact health care delivery, but are restricted in care provision by varying state regulations and reimbursement policies. Although research shows APRN care to be safe, cost-effective, and of high quality, most medical professional organizations continue to oppose the removal of scope-of-practice barriers, citing patient safety concerns. Federal and state laws and regulations, as well as individual hospital bylaws and policies, can block hospitalized patients’ access to their provider of choice, if that provider is an APRN. Removing barriers to care reduces costs, increases consumer choice, and improves health care quality.ⁱ Although the work of the Federal Trade Commission has led to many state legislative bodies rethinking how they approach regulation of advanced practice, the utilization of a mandatory collaboration clause is the foundational base upon which physicians and other groups control the method and manner in which APNs practice. It must be eradicated to ensure full access for patients and full scope of practice for providers.

Intrinsic to nursing is the collaborative process: nurses and physicians working together and independently assessing, diagnosing, and caring for consumers by preparing patient histories, conducting physical and psychosocial assessments, and reviewing and discussing their cases with other health professionals to determine the hanging health status of each client. Yet nursing input and participation in the diagnostic and care process has been discounted by physician providers, state regulation and professional nurse organizations’ desire to distinguish nursing from the medical profession. Nurses and physicians have understood the reality of their work and practice – the nursing process - just as the medical process requires both professions to collaborate to determine the best diagnosis and care plan for the patient. And with this overlap in scopes, practices, and patient care, there is little literature, research and virtually no legislation that clearly provides a balanced accounting of the benefits of collaboration.

Expressing APN practice as a continuum of registered nursing practice was an attempt by organized nursing to remain linked to the profession, however, with the deficiencies incorporated in state scopes of practice, nursing often inadvertently created limitations on scopes of practice. As noted by Safrietⁱⁱ and Hadleyⁱⁱⁱ, early nurse practice acts were generally constructed around their medical counterparts and were written to avoid conflict in professional practice. In the context of professional regulation, nursing scopes were structured to include narrowly defined independent functions and to mandate a dependent or complementary role for nurses.^{iv} Physicians, as the first regulated category of health care providers, attempted to incorporate all aspects of diagnosis and treatment

into the definition of medical practice.^v Nurses, recognizing the limitations created by early medical practice acts, attempted to write practice requirements to circumvent physician-imposed limitations when developing nursing scopes of practice. At that time, the medical profession was virtually all male and nursing almost all female; divisions and attitudes toward and between the two professions often reflected these gender differences. The debate about regulation was limited to elected officials and regulators who, at that time, were almost exclusively male, and who brought a male perspective to regulation. Nursing continued its thoughtful and deliberative studies and discussions on regulation and licensure, but their ideas and recommendations were then interpreted by male legislators and lawyers when incorporated into statute. Not fully understanding the concerns of nurses, legislators and regulators continued to perpetuate a model of health regulation that confined nurses to a largely complementary role in providing health services.^{vi} Part of the interpretation and a concession to physician concerns was the inclusion of mandated collaboration in APN licensure laws and regulations.^{vii}

Nurses, including APNs, have always practiced in collaboration with other professionals - physicians, pharmacists, other nurses, social workers - and a wide variety of health care practitioners. Arguably more than any other category of health care professional, nurses has understood that good patient care depends on the contributions and interactions of various providers. Currently, health care is increasingly being provided in large, complex systems of care with extensive technological support which ensures that no provider works in isolation. Even physicians, who have served as the very model of independent practice, rarely practice alone. All providers collaborate.

If collaboration is the norm in professional practice, why do APNs object to it as a requirement for advanced practice, prescriptive authority, or for reimbursement?^{viii} There are a number of reasons. First and foremost, all health care professionals collaborate, but none have mandates to collaborate within their licensing law but for APNs. APNs do not understand why they have been singled out as required parties to collaborate. APNs also object to the practice of legislating their practice patterns. Determining what kind of relationship is needed with other professionals, when it is needed, and what form it should take are questions of professional judgment and institutional/practice norms. Not only are legislative and regulatory requirements inappropriate substitutes for professional judgment, such requirements are unlikely to provide the flexibility needed to fit the wide variety of clinical situations and physician-nurse interactions necessary to be effective in the first place. (One can only imagine the reaction of organized medicine would have if state legislators attempted to incorporate a definition of collaborative practice in medical acts.) Further, with no standard definition of "collaboration" exists in nursing or other statutes^{ix}, many physicians use this term as a euphemism for "supervision."

Data indicates that mandatory collaboration provisions have been misused by physicians as a means to 1) compel payment; 2) force APNs to refer cases to the collaborating physician; or 3) as a method to steal the APN's client base. ^x Placing a monetary value on collaboration is virtually impossible – it is essential to the nurse who wants to set up an independent practice. Thus, the nurse is the weaker force in the bargaining process. Anecdotal data indicates that APNs have been quoted prices which exceed 30% of the receivables for services, based on reimbursement and traditional insurance rates.^{xi} Advanced practice nurse have shared their experiences with me, telling me of instances where they have been forced out of independent practice because the paid physician collaborator was harassed by other physicians or inappropriately reported to state boards of medicine (SBOM).^{xii} However, no studies have been conducted or lawsuits filed to challenge the practice; and few instances of usury have been documented for fear of retribution and retaliation.

Mandated collaboration or supervision often requires nurses in advanced practice to negotiate the hurdles of business formation^{xiii}. With limited state interpretation of statutes, many physicians use the law to force nurses

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out of business and compel sales of nurse practices. Anecdotal evidence on list serves and blogs reflects a practice of physicians entering into “partnerships” with nurses then firing nurses who are unable to find new collaborators or recoup the value of business created during this relationship^{xiv}. The combination of mandated collaboration with prohibitions against nurses establishing or joining professional corporations or partnerships^{xv}, exacerbates the inequity of nurse physician business relationship, and relegates the nurse to employee status. Collaboration and/or mandated supervision colors the approaches taken by hospitals and insurance companies to the utilization of nurse hospitalists and the credentialing and privileging process, often leaving nurse practitioners as less than equal partners in patient care.

Federal law makes collaboration even more complex and cumbersome with the requirement that the APRN have a formal collaborative or supervisory agreement with a physician or other health care provider "provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed"^{xvi}. However, individual state requirements are widely variable, with little consistency in language and terminology. Twenty-two states have no supervisory requirement^{xvii} (National Council of State Boards of Nursing, 2005). In such states, then, an APRN can practice without a collaborative relationship but cannot receive Medicare reimbursement for the services provided in that practice. Additionally, in every state, including the eight without collaborative practice requirements, APRNs must have physician collaboration in the care of hospitalized patients as the result of federal hospital regulations (Buppert, 2002; CMS, 2005). Thus, state and federal collaborative statutes are barriers to practice; and any statutes which include such should be reviewed with suspicion.

Federal Barriers to Care and Practice

Although the federal government has been an innovator in the expansion of practice, some barriers exist which have been nurtured under the guise of retaining outmoded health delivery models. Two of these limitations are the structure and complex nature of federal laws and regulations related to Medicare and Medicaid reimbursement; and federal control substance laws regulating opioid prescription.

NPs are authorized to perform nursing and physician services. If an NP is performing a service billable to Medicare Part B as a physician service -- in general, a service described by a code found in CPT [5] made necessary by a diagnosis described by an ICD-9 code, [6] -- the NP does not need a physician's order to perform the visit, and could bill Medicare under the NP's provider number and received 85% of what physicians are paid for that service. However, if an NP is providing nursing services -- billable under Medicare Part A -- the NP would need a physician's order for the visit (physician supervision), and the bill would be submitted by and paid to the agency, clinic or practice under the physicians name and billing number.

Medicare regulations require APRN have a formal collaborative or supervisory agreement with a physician or other health care provider "provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed" (CMS, 2005), if the nurse is providing care in a nursing home or other care setting. The physician has to review the nursing plan of care and periodically conduct physicals of the person to ensure the APRN is providing care consistent with the care plan. Individual state licensure law requirements differ considerably and eleven states have no supervisory requirements for practice or prescribing. And another five states merely require collaboration on prescribing, not treatment. In these states, APRN can practice virtually independently but cannot receive Medicare reimbursement for services provided in that practice.

Thus, a nurse who owns her practice or agency and can provide care independently has to develop a collaborative, reimbursed relationship with a physician. And, the nurse has to work at maintaining impeccable records

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documenting the collaborative process and adherence with Medicare visitation and documentation requirements. Because the entrepreneurial nurse provides care and typically bills for services – their work (and billing) are not structured around a collaborative practice model, thus their billing triggers review by fiscal intermediaries which are obligated and compensated to identify and prosecute fraud and abuse. Although the nurse may bill directly or incident-to (with physician primary assessment, development of course of treatment), without an appreciation for the nurse-managed business model, the HHS OIG focuses on nurse entrepreneurs as potential abusers of the Medicare payment system. In a 2002 report to Congress, the Medicare Payment Advisory Commission (MedPAC) examined these practices, found “no specific analytic foundation” for the disparity in payment rates^{xviii} and called for further study of the issue. The structure of this relationship begs FTC review and comment given the obvious barriers to practice. There is a need for the federal government to look internally and to address the inherent barriers to APN practice created by the Medicare billing practices.

Thus, the APN with an independent practice who bills Medicare has to:

- Pay for a physician collaborator;
- In certain instances, i.e. nursing home consults, has to have his/her patients and care plan reviewed by physicians which can create additional charges;
- Negotiate with physicians about who pays the surcharge for malpractice insurance coverage associated with collaboration;
- APN receives 85% of the physician pay to provide similar services

Additionally, the process for development and valuation of codes begs for change. The lack of information on NP coding practices is a consequence of reimbursement guidelines that existed prior to the Balanced Budget Act of 1997. Before the Balanced Budget Act of 1997, NPs provided and coded for healthcare services but were required to bill under a physician’s reimbursement number^{xix}. Therefore, the services provided by NPs were hidden and embedded in the physicians’ services in national practitioner databases. This “bundling” of services for reimbursement made it difficult to accurately distinguish which healthcare providers were providing which services^{xx}. Thus, many APNs provided services “incident to” or in a supervised relationship which they cannot provide independently; and nurses have limited input into the coding system used by the federal government as that system is owned, maintained and developed by the American Medical Association. HCPCS Codes, Healthcare Common Procedure Coding System numbers, are the billing codes used by Medicare and monitored by CMS, the Centers for Medicare and Medicaid Services. They are based on the [CPT Codes \(Current Procedural Technology codes\)](#) developed by the American Medical Association.

The American Medical Association (AMA) first developed and published CPT in 1966.^{xxi} The CPT Editorial Panel is responsible for maintaining the CPT code set. The Panel is authorized by the AMA Board of Trustees to revise, update, or modify CPT codes, descriptors, rules and guidelines. The Panel is comprised of 17 members. Of these, 11 are physicians nominated by the National Medical Specialty Societies and approved by the AMA Board of Trustees. One of the 11 is reserved for expertise in performance measurement. One physician is nominated from each of the following: the Blue Cross and Blue Shield Association, America's Health Insurance Plans, the American Hospital Association, and the Centers for Medicare and Medicaid Services (CMS). The remaining two seats on the CPT Editorial Panel are reserved for members of the CPT Health Care Professionals Advisory Committee.^{xxii} Nurses and other nonphysician providers sit on advisory committees, and make recommendations, serve as a resource to the full committee of physicians; however, the advisory committees do not have full participation in the voting process. In short, the process limits the ability of non-physician providers to have full participation in the code development process. CMS’ reliance on the AMA to develop and determine which codes are appropriate for use of

practitioners ultimately constrains full development of nonphysician practices. APNs and other non-physician providers are restrained by code limitations. This is another barrier to competition used and supported by the federal government.

Likewise, the Medicare certification process also impedes the ability of nurse practitioners to practice independently. The primary Medicare certification organization – the Joint Commission – treats nonphysician providers as licensed independent providers (“LIP”). Though nurse practitioners are allowed to practice and prescribe independently in many states, questions abound as to whether APNs should be lumped with other practitioners who are required by law and certification to practice in a supervised structure. In comments on the CMS/Joint Commission regulations on LIP, one organization stated that 'licensed independent practitioner' is the most problematic language in JOINT COMMISSION's standards and argued that use of this term might result in inappropriate limits on its constituents' scope of practice. This organization explained that the phrase is given wide and varied interpretations by both hospitals and JOINT COMMISSION surveyors.^{xxiii} The JOINT COMMISSION standards mandate physician review of care and treatment plans of LIP and further require physician supervision of “complex care”. When applied to APNs, the standard obviates the nurse practitioner-patient relationship by forcing the nurse practitioner to introduce another practitioner into the relationship, regardless of the need for additional review or the patient’s desires.^{xxiv} Further, these JOINT COMMISSION standards add to the cost of care. The patient is required to pay for his/her practitioner and the services of a physician. Moreover, the nurse practitioner has to explain why this third party is mandated to intervene in the hospital setting, when such intervention may not be required in the clinical setting. In short the requirement creates a market balanced toward protecting the economic interests of physicians.

In addition to restrictive reimbursement policies, nurse practitioners often have other problems with health insurers. Specifically, health insurers and managed care providers are reticent about placing nurses on provider panels or alternatively, once the provider has been placed on a panel, the nurse may find him/herself removed arbitrarily, by no fault of their own. Even with the history of licensure and national certification of nurse practitioners, nurse practitioners cannot rely on acceptance through institutional credentialing. Often, the NP encounters physician peer review committees which are not designed to evaluate nurse practitioner practice; or supervisory requirements for credentialing (although state law allows for NP independent practice). Some institutions hire NPs as employees and treat them as physician extenders. Other institutions or insurers create a “credentialing” process for NP employees. And, seldom, if ever, are 13ANA expressed its concerns to the JOINT COMMISSION about the Licensed Independent Provider standards in comments dated March 17, 1995 (Attachment F). nonphysician practitioners allowed to sit on committees for bylaw development and seldom are nonphysician practitioners given full voting privileges. The reality is that hospital and health care credentialing of nurse practitioners seldom provides the benefits or support system granted to physicians. To place perspectives on market imperfections, I would like to share with you the e-mail of a nurse practitioner that I received on February 6th .

There are many other barriers to APN practice perpetuated by the federal government to include the arbitrary exclusion nurse practitioners from dispensing buprenorphine, a drug used for opioid withdrawal; and the FDA preliminary decision to limit nurse dispensing of certain schedule II opioids. While we appreciate the desire to control availability, the decision was not based on data presented to the FDA, as there is no data which supports or intimates that nurses are any more likely to inappropriately prescribe opioids than physician providers.

We live in evolutionary times. No one envisioned APNs would practice independently when licensure statutes were written. Our health system was built on the premise that physicians would serve as captains of the ship, Health Care Workshop, Project No. P13-1207

leading and directing care. That has changed. We live in a world where technology infused into healthcare delivery supports and enables all practitioners to be better providers. Nursing curriculum has changed over the 47 years since the first APN was created. APNs have been providing safe, sound care in supervised and independent settings for over 40 years. Lift these additional and onerous barriers to practice which are no longer needed and were designed to placate physician professionals. Mandatory collaboration exists for all health care professionals. If providers do not collaborate, care is incomplete. Singling one set of providers out to mandate such legislatively sends an inappropriate message about the quality of their practices; and opens doors to inappropriate uses of the terminology. It also allows other providers to use the language to collect additional fees from APNs which are a barrier to independent practice.

Government healthcare agencies perpetuate barriers by retaining systems and processes that reinforce physician hierarchies. Reimbursement policies, to include the government healthcare reimbursement coding used and the process for code development need to be changed for equal input by all healthcare providers, even if that means developing a new reimbursement code. Joint Commission regulations should be changed to incorporate APN as full providers who can request physician review of care, without a physician review mandate. This standard obviates the nurse practitioner-patient relationship by forcing the nurse practitioner to introduce another practitioner into the relationship. If the federal government seeks to support new and innovative practice models and remove barriers to competition and comprehensive health care delivery by all parties, the federal government should start with itself when purging barriers to practice. And, we believe that the Federal Trade Commission has the mandate to begin addressing these practices within U.S. government agencies.

ⁱ American Academy of Nurse Practitioners, "AANP Comments on the IOM Report," accessed August 5, 2011. http://aanp.org/AANPCMS2/publicpages/AANPIOMResponse92Date8_4_11.pdf.

ⁱⁱ Safriet, B.J. "Health care dollars and regulatory sense: the role of advanced practice nursing." *Yale Journal of Regulation* 9:417-488, 1992.

ⁱⁱⁱ Hadley, E.A. "Nurses and prescriptive authority: a legal and economic analysis." *American Journal of Law and Medicine* 15:245-299, 1989.

^{iv} Safriet, B.J. "Health care dollars and regulatory sense: the role of advanced practice nursing." *Yale Journal of Regulation* 9:417-488, 1992.

^v Safriet, B. J. (1992) and Hadley, E.A. (1989) touched on the concept that organized medicine attempted to confine nurses to a largely complementary and supervised role through the development of "all-inclusive medical scopes of practice."

^{vi} Hadley, *ibid*

^{vii} Robert L. Phillips Jr., Doreen C. Harper, Mary Wakefield, Larry A. Green and George E. Fryer Jr. Can Nurse Practitioners And Physicians Beat Parochialism Into Plowshares? *Health Affairs*, September 2002. Accessed April 30, 2015 <http://content.healthaffairs.org/content/21/5/133.full>

^{viii} Antoinette DeBois Inglis and Diane K. Kjervik, Empowerment of Advanced Practice Nurses: Regulation Reform Needed to Increase Access to Care. *Journal of Law, Medicine and Ethics*, Volume 21, Issue 2, pages 193–205, June 1993. Accessed online April 30, 2015, <http://onlinelibrary.wiley.com/doi/10.1111/j.1748-720X.1993.tb01242.x/abstract>

^{ix} Tracy A. Klein, MS, WHCNP, FNP, Scope of Practice and the Nurse Practitioner: Regulation, Competency, Expansion and Evolution. *Topics in Advanced Practice Nursing eJournal* 5(2): 2005. Medscape. Accessed April 30, 2015 <http://www.oregon.gov/OSBN/pdfs/kleinmedscapearticle.pdf>

^x Jolynn Tumolo, "Paying for Collaboration". Advanced Healthcare Network for NPs and Pas, accessed April 30, 2015. <http://nurse-practitioners-and-physician-assistants.advanceweb.com/Article/Paying-for-Collaboration.aspx>
See also "what is a fair fee to pay a supervising/collaborating physician?" Clinician One blog posts, accessed April 30, 2015. http://clinician1.com/posts/article/what_is_a_fair_fee_to_pay_a_supervising_collaborating_physician/

^{xi} None of the states which regulate collaboration include provisions regulating the cost of collaborating. And none of the mandated collaboration provisions address good faith entry into or surrender of the collaboration

agreement. Thus, there are no penalties for charging excessive fees for collaboration; or requiring physicians to indicate reasons for terminating these agreements, but for provider incompetence. And, there are no penalties or prohibitions against terminating agreements for fraudulent or anticompetitive purposes. In short, nurses have to litigate to prove anticompetitive behavior, in the absence of a standard for making the determination.

^{xii} Few medical organizations provide concrete data or discuss the negative/anticompetitive behaviors which have developed around mandatory collaboration/supervision; and I wish to share some of these concerns with the committee. Specifically, some physicians retaliate against not just against nurses but also other physicians who chose to collaborate with nurses. *Nurse Midwifery Assocs. v. Hibbett*, 918 F.2d 605, 614-15 (6th Cir. 1990) highlights this phenomena. This case involves two appeals arising out of an antitrust action brought by two nurse midwives, the obstetrician with whom they had affiliated, and three of their clients, against three Nashville hospitals, certain members of the medical staffs from two of the hospitals, another practicing obstetrician in Nashville, and a physician-controlled insurance company. The plaintiffs alleged that the hospitals and medical staff conspired to restrain their practices, in violation of section 1 of the Sherman Anti-Trust Act, 15 U.S.C. Sec. 1; and they successfully proved that the hospitals and medical staff retaliated against them and the physician who agreed to supervise their work.

^{xiii} Until the Federal Trade Commission drafted opinion letters to address anticompetitive proposals introduced in states by state medical associations, the associations used a strategy which included more restrictive collaboration provisions in Tennessee, Texas, Oklahoma and Illinois to undermine the cost-effectiveness of nurse practitioner staffed retail clinics. See also FTC Staff Comment Before the Massachusetts Department of Public Health Concerning Proposed Regulation of Limited Service Clinics, 2 (Sept. 27, 2007), *available at* <http://www.ftc.gov/os/2007/10/v070015massclinic.pdf> ; [FTC Staff Comment to Representative Elaine Nekritz of the Illinois General Assembly Regarding House Bill 5372 Concerning the Regulation of Retail Health Facilities](#) (June 2008) (V080013)

^{xiv} A Missouri ARNP in an academic medical center practice was fired without cause, after working to develop a clinical practice; and all of the medical center physicians refused to practice with her subsequently requiring her to relocate and leave the practice she helped build.

^{xv} See TN Atty. Gen., Opinion No. 07-116 (August 8, 2007). On August 8, 2007, the Tennessee Attorney General issued an opinion addressing the ability of nonphysician practitioners, such as certified nurse practitioners, registered nurses, advanced practice nurses, licensed practical nurses, and physician assistants (Non-Physician Practitioners), to own and operate professional practices providing medical services (the Opinion). The Opinion addresses two specific questions relating to the professional practice of Non-Physician Practitioners, each of which is briefly summarized below.

Is it lawful for a Non-Physician Practitioner to own and operate a professional practice through which medical services are provided?

The Opinion states that, as a general rule, no Non-Physician Practitioner may own and operate a medical professional corporation (MPC) or a medical professional limited liability company (MPLLC) for the provision of medical services.² However, there are certain statutory exceptions for a physician assistant (but no other type of Non-Physician Practitioner) to own *part* of an MPC or an MPLLC in combination with certain licensed physicians or physician entities.

Is it lawful for a physician to be an employee or independent contractor of a Non-Physician Practitioner for the sole purpose of providing the supervision, responsibility, and control required by law for medical services provided by Non-Physician Practitioners at their remote practice sites?

The Opinion concludes that a physician may not be an employee of a Non-Physician Practitioner for the sole purpose of providing supervision, responsibility, and control for such Non-Physician Practitioner at his or her remote practice site. However, the Attorney General distinguishes that a physician *may* be an independent contractor of a certified nurse practitioner, advanced practice nurse, or physician assistant for such sole purpose.

In the Attorney General's view, the critical distinction between employee status and independent contractor status turns on the following analysis. First, the Attorney General states that based on its analysis of the corporate practice of medicine doctrine described above, it is not lawful for a licensed physician to be employed by a non-physician unless a specific statutory exception applies. Second, the nature of the employer-employee relationship requires the employer to exercise supervision and control over the employee, a relationship which would run afoul of the statutory requirement that a physician exercise supervision, control, and responsibility over the Non-Physician Practitioner's provision of medical services – if the Non-Physician Practitioner is in fact the employer. The entire opinion may be found at <http://tennessee.gov/attorneygeneral/op/2007/op/op116.pdf>

^{xvi} Michael A. Frakes, Tracylain Evans, An Overview of Medicare Reimbursement Regulations for Advanced Practice Nurses, *Nurs Econ.* 2006;24(2):59-65. Reprinted with permission by Medscape. Accessed April 30, 2015 <http://www.medscape.com/viewarticle/531035>

^{xvii} 22 states and DC allow NPs to diagnose and treat without physician involvement: (AK, AZ, CO, HI, ID, IA, KY, ME, MI, MT, NH, NJ, NM, ND, OK, OR, TN, UT, WA, WV, and WY. NCSBN, Scope of Practice FAQs for Consumers Advanced Practice Registered Nurses (APRNs) Accessed April 30, 2015 <http://www.nacns.org/docs/toolkit/3A-FAQScope.pdf>

^{xviii} Medicare Payment Advisory Commission. Report to the Congress: Medicare payment to advanced practice nurses and physicians assistants. Washington (DC): MedPAC; 2002 Jun.

^{xix} Health Care Financing Administration (HCFA). (1998). Increased Medicare payment and billing requirements for nurse practitioners (NPs), physician assistants (PAs) and clinical nurse specialist (CNSs)-Balanced Budget Act of 1997 (DHHS publication No. AB-98-15). Washington, DC: U.S. Government Printing Office

^{xx} Rapsilber, L., & Anderson, E. (2000). Understanding the reimbursement process. *The Nurse Practitioner*, 25 (5), 36, 43,46,51-52, 54-56.

^{xxi} American Medical Association, CPT® Process - How a Code Becomes a Code. Accessed April 30, 2015. <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/cpt-process-faq/code-becomes-cpt.page>

^{xxii} Ibid.

^{xxiii} Department of Health and Human Services. Centers for Medicare & Medicaid Services. Federal Register Volume 71, Number 236 (Friday, December 8, 2006). <http://www.gpo.gov/fdsys/pkg/FR-2006-12-08/html/06-9559.htm> Accessed January 1, 2013.

^{xxiv} Carolyn Buppert, NP, JD, Is an NP a Licensed Independent Practitioner? *Medscape Nurses*, January 17, 2013 Accessed April 30, 2015. http://www.medscape.com/viewarticle/777639_3