NATIONAL ASSOCIATION OF
CLINICAL NURSE SPECIALISTS

November 24, 2003

Donald S. Clark
Office of the Secretary
Federal Trade Commission
600 Pennsylvania Ave. NW
Washington DC 20580

Dear Mr. Clark:

As suggested by the office of Mr. David Hyman, I am forwarding comments received in support of the testimony presented by the National Association of Clinical Nurse Specialists (NACNS) on June 10, 2003 concerning the relevance of the Noerr-Pennington Doctrine and state recognition of the practice of Clinical Nurse Specialists (CNSs). In that testimony, we indicated that the state boards of nursing prevent CNSs from practicing in their fields of expertise because of external influences exerted by special interest groups. Consequently, citizens are being deprived of competent, specialized and cost-effective health care.

We have received input from over forty CNSs in twenty states who have suffered professional and pecuniary harm because of the national confusion by state boards of nursing in recognizing a form of advanced nursing practice that does not impinge on the practice of other licensed professions. We are submitting only those comments that indicate the breadth of the geographic scope as well as the undue hardships imposed upon applicants for recognition as CNSs in many states.

The first, and only multiple paged, of the comments enclosed outlines and describes the bureaucratic channels created for and deterrent to state recognition of CNSs. The ensuing comments give support to our contention that state boards of nursing across the country are depriving our citizens of necessary, cost-effective health care by not recognizing the advanced practice of Clinical Nurse Specialists.

NACNS would be pleased to provide additional clarification or comments that you might require.

Sincerely,

Christine Carson Filipovich

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Executive Director

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Comments Regarding Health Care and Competition Law and Policy

I allowed myself two weeks to gather my thoughts regarding my post payment audit hearing with a contracted CMS hearing officer. As requested, I am sending a copy of the letterhead with the officer's correspondence to me. As you can see, her letterhead indicates "WPS" on some occasions, and "CMS" on others.

As I had described to you, I am feeling very beaten up by this whole process. The audit was conducted based upon documentation from 1999. The audit letter originally indicated that according to their tables, I had been using a larger than normal number of codes indicative of a 50 minute duration for the home and 35 minute duration for the nursing home. In addition, the letter stated that I was the only one doing this care in the state of Illinois. If that were the case, then where did the tables of typical number of code use versus what I was doing come from?

I was the only advanced practice nurse as a Part B provider in Illinois rendering wound care services to the most vulnerable and needy population, i.e., the poor, elderly and disabled that were homebound and in long term care facilities. The rationale for this is simply that these individuals can't readily get to a clinic setting for services or afford transportation to a clinic setting. My mission is to provide **one standard of practice regardless of payer source**. As a result, my population is the very urban city of Chicago that no one else wants to see, as well as rural Illinois.

As I had previously stated to you, I submitted all data in a 3 week time frame. The number of documents amounted to approximately 144 different dates of service reflecting home care and long term care patients with wounds. Some cases were initial evaluations, and some were follow-up evaluations. I was not late in any of my submission, and kept all my certified post-office verification statements of when the items were submitted and signed for.

In May of 2002, I received a letter demanding $ 8,000. associated with denials of all debridements and all visits cut down to the lowest levels regardless of severity of the patient. When I saw this pattern, I wanted to have a hearing to challenge the auditor's decision before I paid any amount of money.

I am careful in my documentation of severity according to established standards of practice associated with wound etiology, as well as attempting to meet the designated time frames of what CMS expected in 1999. Wound care descriptors in 1995 and 1997 guidelines were not as specific as the comprehensive tool that I used for everyone regardless of setting. The rationale for this is associated with the AHCPR guideline regarding wound care published in 1995. It is my clear perception that the disease and standard of practice that is published and evidence based, and can be held valid in a court of law, supercedes a loose interpretation of documentation for reimbursement.

I know that I had addressed prior issues of intimidation by the officer. Her initial conversations with me were accusations of fraud in caring for patients that had skilled

providers from home health and seeing patients in Part A beds in a long term care facility. I corrected the officer by stating that I am not to be equated with the "skilled provider" since my role is to determine etiology, run diagnostics and make recommendations **as the physician**, i.e., a professional provider of service.

During a subsequent conversation, she stated that we should only see long term care patients monthly, and not with the frequency as stated. In communication with the state of Illinois, I received and faxed the Illinois guideline for nursing home patient evaluation which stated that **routine** evaluations occur at that frequency, but when a patient presents with a problem, it is up to the professional discretion of the practitioner to determine when to evaluate and manage the patient.

It became evident that when she called for information and to set a date for the hearing, she did not have all the data. The officer kept pressing for a date. My response to her was how could she set a date for a hearing when she didn't have pictures and supportive documentation? At my expense, I sent all documentation to her attention. She then specified that it would be in my best interest to have an in-person hearing. This necessitated coordination of my time with my consultant's and my biller. This discussion was predicated by open threats that if I changed dates, she would render a decision on the spot. I reminded her that I never changed a date. She, however, became ill at the original established date, and a subsequent hearing date had to be made. I would not provide a date until she had all information to review.

After the threats and over-the-phone castigation, I contacted her supervisor, and conducted a 3 way conversation between the supervisor, my biller and myself. The consultant, my biller and I had all been treated with nasty accusations and had enough of this behavior. With the supervisor, I explained by perceptions and threats. She then contacted the assigned officer to discuss the process and conduct of a hearing. I also put my concerns in writing to request another hearing officer. She submitted a document as to why, according to her book of statutes, she didn't have to relieve herself of the case. In essence, while I supposedly had rights, those rights could all be denied pending whatever the hearing officer felt.

On repeated occasions, she stated we should have used a code 97601 for billing debridements. I repeatedly informed her that this code was not in existence until after 1999, and that my professional organization provided me with information about which codes to utilize in addition to continuing education I attended regarding how to code. I sent samples of my professional organization's written fact sheets to her attention.

When the hearing date was finally set, I requested that the physician who performed the evaluation of my documentation be in attendance to talk to me. I wanted a professional face to face dialogue with the individual. This was my whole purpose for a face to face encounter. My biller, consultant and I arrived at the hearing. The physician never entered the room to talk to me. He never acknowledged any of his decisions with me in person the entire afternoon that we were there.

The hearing officer initially confronted me about the number of cases seen and her disbelief in how I could personally see so many cases myself (10-12, or 16 in combination with rounds at long term care facilities). It is not atypical to be able to see a consolidated group of patients in a long term care facility and travel to another location to further see patients. I have seen 12 cases in one day. If I followed the physician reviewers logic, i.e., each long term care patient seen was only worth 5-10 minutes of my time, I could have seen up to 40 cases a day!!! I certainly have not seen any data from CMS re: typical number of cases seen in one day for wound care patients. Who conducted this time study? This issue was never part of the original audit.

I did utilize other support of certified specialists who were waiting for their UPIN numbers and Medicare provider numbers to be granted. This process, took approximately 10 months to occur!!! While I used these specialists to assist me, I made sure I had seen all patients, and conferred on all plans of treatment and recommendations, all recommendations came from me.

I am aware that when ancillary staff, without degrees, titles and certification see patients under the 99211 code, i.e., to perform a defined task, i.e., blood pressure evaluation, lab draws, injections, that the visit and evaluation does not require the physician to be present, and the charge and coding fall under the lowest visit rate. The reality is that my staff had advanced practice degrees and certification and we are fighting over being paid $35.00- $ 45.00 per case.

Even the HIM 11 allows nurses with as little as two year degrees to supervise LPN's in caring for a patient. The LPN may have one year of general expertise, but no experience in wound care, is performing a patient evaluation, and getting reimbursed under the Part A guidelines at a facility visit rate of $110-125.00 per visit. There is no mandate that the RN has a face to face encounter with the patient for supervision of the LPN at each evaluation, but only every 6th patient encounter!!! In addition, these individuals are performing procedures that they have never received continuing education for, know how to apply, or can't recognize side effects or adverse reactions to appropriately report findings to the physician or practitioner!

I was required to make a list of all cases I personally saw and all cases seen by the other practitioners. She stated that she would take back those cases seen by the other practitioners, but I could resubmit under their numbers. However, the timeline for resubmission was over!!! One of my staff members had another Medicare number, but because it was not under my business, it didn't apply. My staff had to reapply for Medicare numbers when they came to work for me. The processing of these numbers took 9-10 months of weekly hounding!!! Do doctors have to reapply for their Medicare numbers, or is that something they take with them from one location of service to another? Does it take 9 months for them to obtain their numbers? How do you keep a business running if you must wait for their numbers in order to bill for visits obtained. I already was placed in a position of borrowing money since the Medicaid system in Illinois had no funds, and payment was delayed by 8 months.

In dialogue about the debridements, I was armed with documentation from the CMS communication bulletins from 1999 and 2000 that stated I could use the 11040 series codes because that was all there were to use. The hearing officer stated that those codes were interpreted to be only for physicians and only related to surgical debridements with patients under anesthesia. This was not substantiated by other coding experts or by the customer service department of CMS which did state that I could use these codes for my mechanical, hydrodebridement and sharp debridement procedures. The hearing officer then stated that I should make a list of all sharp debridements done at this time, and she would pay me for those only. All my debridements listed at that time were mechanical or hydrodebridement with pulsed lavage systems.

Further communication directly with CMS revealed that the hearing officer is confusing the 13000 and 14000 code series with the 11000 codes that I used. CMS also stated that even though a bulletin was released about use of 97601 in January of 2001, it was rescinded and pulled in June of 2001. This is the ultimate confusion as the biller does not have any straight guidance on how to bill correctly for services performed, and I am losing money in the process of already not being paid appropriately.

The hearing officer felt that documentation did not have to be so thorough on subsequent visits. My response was that the standard of practice for wound care is published with its own frequency of re-evaluation and documentation pertaining to all practitioners and must be upheld. She then stated that the time frames should indicate a level of severity. I produced my severity stratification system that was evidenced based and done by other physicians to support the level of severity. She felt that at my level, there would never be a time of using a 50 minute code. I indicated to her that it does take time to evaluate a patient, turn them, clean them, educate the caregiver, debride at the bedside and evaluate comorbids causing skin breakdown. In 1999, there was no extended visit code accessible for documentation. In addition, the systems of time and severity coding were known by CMS to be faulty regardless of if the 1995 or 1997 guidelines were used. I am including a presentation done by CMS that stated how specialty groups did not fit the mold and how the guidelines would not truly be indicative of their performance. In addition, CMS has no outcome information about wound management performed in 1999 according to their guidelines. I, however, have data to support the number of cases seen, patients healed, and cost per case per wound etiology.

All this was meaningless to the hearing officer as she stated: “Medicare doesn’t care about Quality”. This is obvious given the fact that doctors will be allowed to perform wound care without any formal training in wound care or continuing education specific to this realm before being able to see cases and bill for them. The MD title can allow them to receive full reimbursement without knowing anything about wound care. As a result, the government ends up spending more for the amputations caused be poor decision making, lack of thorough diagnostics and outdated treatment modalities. Patients with gangrene were inappropriately debrided. Infections not aggressively attended until sepsis caused acute care management. Grafts and flap failures abound related to the ineptness of the surgeon in thorough evaluation of the patient and determination of candidacy for the procedure. Just as a transplanted body organ fails, so have the flaps.

This is the population of patients that I see, the failures that someone else couldn't fix. Home care agencies that hire LPN's and nurses not proficient in wound care are allowed to make recommendations on product and treatment utilization. Given the bundling under prospective pay system, the home care agencies established formularies driven by cost containment. As a result, products that are research based with proven efficacy are not used. I doubt that patients and their families are signing up for home care with full disclosure that they are being treated with products that are not research driven, and in many cases prolonged patient pain and suffering. There is even a DME company that touts a comparative chart of their products versus the competition. The only problem is the chart does not compare similar products that have research to support their brand.

To make matters worse, skilled staff, i.e., home care nurses and LPN's are able to recoup more money per patient visit for a home care agency, than a professional caliber nurse, i.e., the advanced practice nurse. The visit rate for a home care nurse I from $110-125. per visit, while my return visits will recoup $ 55- 80. per visit.

When this was brought to her attention, she reviewed the CPT book, current and not from 1999, and stated that we should look at the beginning of the book and end of the book. I stated that there needed to be formal guidelines for NP and CNS to follow and resources made readily available. I had no idea that I was responsible for information in a Federal Registry. There was no reference to this by CMS when I obtained my numbers, or from the professional organizations that I belonged to at this time.

If I am confused about what codes to follow, I can assure you that the other practicing practitioners don't know this either. Everything I learned came from in servicing conducted by other sources, not HICFA. HICFA didn't have specified in-services for CNS and NP in 1999. How can I be accountable for coding when I can't get a straight answer on a specific resource to follow, or notification by HCFA. I followed what was published in the Part B Bulletin. Be advised that what is printed in the Bulletin is not hard and fast and has changed as quickly as within a month of publication. In addition, when the education department was contacted by my biller for help, the service representative from CMS told my biller that the department no longer exists. When I wrote my letter to Dennis Hastert, the regional manager of CMS indicated that someone from the education department would be in contact with me. It was during the hearing that the officer stated that someone named Eleanor would contact me after the hearing. This has yet to occur.

The hearing officer requested that I type all my E&M sheets that I submitted to her within a 12 day time frame because she couldn't read the notes. Now, I question why this hearing took place if the notes were never read!! If this were the case, why wasn't I informed ahead of time to accommodate her ability to truly read what was done. I am sending samples of what was submitted.

I feel the welfare of the poor, the disabled, and the elderly is worth this battle. I can't do it alone, or seem to get through to CMS that what I do at an average of $ 32.16 per long

term care evaluation/ $ 68.00 per home care evaluation is value added to the livelihood of a wound patient and a health care delivery system.

There was no consideration that what I and my staff did was save thousands of dollars by decreasing bacterial loads, preventing infections, aggressively treating immuno-suppressed patients, preventing amputations and patient sepsis to the most vulnerable of populations, the home bound and those confined to long term care. I have data to support what my costs were in the provision of care. The savings of one patient from having an amputation meant that he did not have to put his wife in a nursing home for Alzheimer's or himself because he couldn't take care of his home. That savings was $72,000. per year. Multiply that by at least 5 years for an amputee's average life and that becomes $360,000. Now multiply this by at least 100 patients which is a very low estimate of the patients assisted in even a two year time frame, and that becomes $3,600,000. To me, this is significant. Not to mention, keeping families from suing home care agencies, doctors and nursing homes for bad care.

Based upon this experience, I am feeling very insecure and confused about me, let alone any advanced practice nurse billing for services under Part B since:

1. Medicare did not provide me with any resource, written text to assist in billing and coding. I had to seek out any resource I could find to address these issues back in 1998. Any presentations I attended certainly were not in conjunction with HCFA, because they didn't exist at this time specific to the CNS or NP. I had to find and hire a billing individual with years of expertise with doctors in coding, dealing with Medicare and preparing for audits. Based upon that expertise, she was willing to assist me in pioneering these efforts in Illinois. If a Medicare official tries to refute this, they need to show me where they made this public knowledge.
   Lack of one set guide to follow and one set location to check for changes.

2. Variance in interpretation within the Medicare system from supervisor to supervisor as well as a hearing officer supposedly representative of CMS that confuses Part A with Part B and location of service, and quotes the HIM 11 which does not pertain to me.

3. No Advanced Practice Nurse or Wound Specialist to review and judge what I did according to standard of practice for wound care.

4. Use of doctors to evaluate my work that were ER doctors who truly don't spend time at the patient's bedside, let alone comprehend what I do
5. Substantiation of what I do with a Plastic Surgeon????!!!! How about I try that with them. A lawyer would debase me in a minute stating that I was not a doctor and could not answer for a doctor because I don't have a doctor's license.

6. Denigration for caring for patients at risk, in risk locations for payment that is less than what is paid to individuals that do not have my or any level of expertise regarding wound care etiology, product utilization, determination of status, prescriptive authority, or capability in performing debridement procedures and thorough diagnostics.

7. No assistance from CMS still since the regional manager wanted to wait until after the hearing form someone to get in contact with me.

8. Restraint of trade: no one can run a business waiting 8-9 months for the UPIN and numbers to finally be obtained. Information had to be resubmitted several times to different departments because it was lost from the original packet of what was submitted. In addition, payment was repeatedly denied, had to be appealed, and held back. In my data, HCFA/CMS was consistently not paying me 20% annually for the last 5 years. This, in addition to only being paid 64% of what the value on the dollar is for an advanced practice nurse coupled with the fact that many secondary insurance companies would not even acknowledge my existence! Blue Cross / Blue Shield of Illinois being the biggest offender to this.

9. While CMS centralized both Medicare and Medicaid crossover payments, it did not recognize the multiple advanced practice levels of expertise, i.e., only paying the midwife, PNP, and FNP. As a result, those of us dealing with the elderly, adult, wounds that qualified for Medicare reimbursement, are denied payment by Medicaid in the State of Illinois. This is not congruent with other states, and since Medicare is federally funded, if criteria are met for a Medicare number, then the same is true for Medicaid as for any other crossover secondary insurance. If this is not the case, it is discriminatory to my practice since this does happen automatically in other states. Is it my imagination, or does federal supercede state regulations? Wasn't this a basic tenet of the Civil War?

My proposal for change:

If CMS is going to judge advanced practice nurses then only an advanced practice nurse can judge their area of expertise, not an ER doctor. I am happy to provide that service since I have been through the mill with this. My fee is $125.00 per hour of consultation. After all, this is what I charge an attorney to review lawsuits rendered by those who don't know wound care and injure a patient, i.e., doctor or nursing home.

Specific course mandated for all NP and CNS when they get their numbers on the codes they can use, and how to document accordingly.
Specific spelled out codes for the NP and CNS that will not be misinterpreted. If I can write clear cut patient education manuals, I can do this as well.

Documentation guidelines that reflect standard of practice guidelines, not what CMS feels like paying on a monthly basis. An insurance provider should always be looking at what is the most efficient and effective mechanism for disease state management according to acuity to prevent crisis situations from occurring. I truly feel that CMS should be held liable for the rules that have caused added pain and suffering to patients, i.e., placing wound care products under a Part A program, managed by individuals that can and have caused serious harm because they don't know what they are doing and have caused prolongation of wound healing, infection and amputation particularly when they use formulary products that have no research to support efficacy in healing. The **professional** clinician determines the course of treatment, not a **skilled provider, and not a payer source. The standard of practice supercedes the payer source.**

Until policies are put in place that reflect where the NP and CNS can practice and who they can serve without discrimination, don't be auditing to slap someone's hand in order to make a policy retrospectively. Don't point fingers of accountability until practitioners know what and where they are accountable.

Stop the discriminatory practices between crossover insurance providers, and qualifications for service. If Medicare grants a UPIN and number, then it is a moot point for Medicaid. Secondary insurance companies part of Medicare, are mandated to also pay the advanced practice nurse regardless of area of expertise. Stop discrimination of paying physicians only in underprivileged locations. Hence, if there is a 10% incentive fee for the physician to practice in these locations, then this is also the case for the nurse practitioner and CNS. They put their lives on the line entering these neighborhoods to service a very needy population and need to be honored for this.

I apologize for the length of this document, but I feel that I had to do something. I do feel one small individual from the state of Illinois can make a difference.

Copy of letter sent by same individual:

Dear Congresswoman Biggert,

I am writing to you for some advice and assistance in a dilemma I am experiencing with CMS, Center for Medicare and Medicaid Services, as a Part B Provider of service. My name is Mary Foote, and I am one of the first advanced practice nurses in the state of Illinois to obtain my UPIN for practice with the advent of the Balanced Budget Act of 1997. I am a struggling small business woman with a staff of 6 other advanced practice nurses that all have master's degrees, certification and have met the guidelines for attainment of their own UPIN numbers and Part B status as well as Medicaid reimbursement. Every month, I pray I can make payroll and pay for the cost of their health care benefits. I am delayed in payment, must appeal denied claims, and sometimes never receive payment by secondary insurance companies or Medicaid. Medicaid is 6 to 8 month behind in paying me for the services that my staff render to the poor, rural and homebound or long term care patients with the worst wounds in the city of Chicago.

In October of 2000, I received a request by HCFA for a post payment audit regarding my patients that I saw in 1999 in the home and nursing home environment. The audit letter contained a table that stated that I was doing more than my peers in certain designated CPT codes. The letter also stated that I was the only advanced practice nurse in Illinois doing this!!! I submitted copies of all my documents within the allotted two week time frame that HCFA provided me. Six months later, March, 2001, I received a request for 4 cases, each representing one visit. There was no connection drawn between the initial request and the second request of the 4 cases. I assumed these 4 cases were to evaluate the use of compression therapy, since this procedure is what all the patients had in common. I again submitted what was requested.

On April 22, 2002, I received a 3 page letter from the investigative department with a detailed table of every case examined requesting $8,600. Two days later, I received a second statement stating that they had made an error and wanted $ 8,200. Back. In addition, they included the 4 cases from March 2001 requesting another $ 208.00.

I examined the lists that were sent, compared with my original post payment audit request, and discovered that they requested money back from patients I never received any reimbursement for in the first place, asked for more money back than what I was paid; and requested money for cases not included in the post payment audit request. Those cases amounted to a significant amount of money, $ 635.32. I asked the investigative department to remove the discrepancies and they refused to do so. They stated that I must pay the entire amount first, and then I can appeal the discrepancies with the appeals department within a 6 month time frame.

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My problem was to get verification from the College where I got my CNS degree. I had completed my CNS degree in 1990. However, I did not actively pursue getting my BRN CNS license until 2000. The college I had attended had since dropped their CNS program and was only providing a NP program. When I tried to get the college to verify the program they would not do it. I spent about 4 months tracking down my CNS professors and having them re-submit their course work to the college to get them to approve the CNS application. It was grueling, time consuming work but now other CNS graduates from my school should not have the same problem. I also had to take a job as an "Educator" at reduced pay until the approval went through. Also, while I was pursuing the CNS verification, I was looking at maybe just trying to get the classes themselves approved but since I was not in an NP track, I did not take an advanced pharmacology class and would have had to take one before submitting CNS application paperwork.

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In the fall of 2001, I moved to California, having been a CNS in both Virginia and Alabama, with a specialty in Maternal-Child Nursing, a Master's Degree from the Medical College of Georgia in l992 in a CNS program, and extensive experience.

I applied for my nursing license, and then expected to further apply for the CNS designation. The license was granted, transcripts were sent, I flew to Sacramento at great expense to accomplish that because of the anthrax scare and all mail being held. I was able to get the license, but the CNS portion has been an uphill battle.

There is no reciprocity. The expense is an additional fee to have your application reviewed through three different avenues, with the State Board Determining whether you met their requirements. I received a letter that I would then have to complete 400 additional proctored hours of clinical experience in my specialty field, enroll and complete two additional courses: Advanced Pharmacology and Advanced Assessment with clinical components and classroom work. I located such courses which are offered on Weekends for 6 successive weekends plus clinicals at an expense of $400+ per unit. I have neither the time nor the funds to take the courses at the present time, and also felt it to be unwarranted since I have no prescriptive rights.

I am in the category for which there is no Examination, and in my two previous states was able to submit a portfolio with Continuing education documentation, affidavits from my employer attesting to my role as a CNS in their facility and copy of my NCC RNC Certification in Maternal-Newborn, with copies of my transcripts.

That had been sufficient in each of those states, despite there being a requirement to pay an additional license fee and hold a separate license. I had no problem with that fee, as I held it to be an additional professional responsibility.

I strongly object to the requirements in California, and have corresponded with them requesting further consideration, and have forwarded the portfolio copies directly from the State of Alabama Board of Nursing to the California Board of Nursing. I await their response. Alabama has been very cooperative releasing official copies of their files, and have sent me the copies of the return receipt as well; it appeared to me that they may have encountered problems with California in the past by that gesture.

I would be very willing to share the correspondence I have had with them and provide any documentation/affidavits necessary to bring this to the forefront.

Yes, it affects me professionally and financially. My program at the Medical College of Georgia has not kept records older than 5 years, has changed from a semester to a quarter system, revised their program, and even contacting the dean of the school, and providing information on my proctored hours, could not document all the required clinical hours that California is requiring. I have my transcripts but no longer have course descriptions, catalogs and full details of the requirements for each class.

I also question the necessity to take either of the two courses. Assessment that is done at the level of a graduate program is already advanced. Will the course I take to meet the "ticket" punch make me any further qualified to assess neonates/laboring women, since it will be a general assessment course? If I am current on the medications with which I work every day, and know their bioavailability, half-life, potential harmful effects and Category of risk for lactation, will I ever prescribe! The answer is an emphatic no...and I question the need to take a further course as well.

I feel it is all about money, as the fee for the license is very high, and the disclaimer states that it only affords the opportunity to apply. If requirements are not met in 3 years, I then must reapply, and resubmit the fee.

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I am ANCC certified as a Psychiatric CNS. I acquired APCNS/prescriptive authority status in Colorado in 2000 and subsequently had 13 months of practicing with prescriptive authority.

In March 2002, I moved to California and have been denied the opportunity to practice at the same level. The California Board of Registered Nursing has limited my scope of practice. The initial denial letter alludes to a deficiency in my curriculum content for California NP certification. I appealed the decision and asked for a second evaluation that, like the first, was non-specific and carried the recommendation that I attend a school offering NP training.

I earned prescriptive authority by taking additional course work and meeting supervisory requirements beyond my CNS master's preparation. I met the requirements to practice at this level including having a DEA number and Medicare number.

The limiting of my scope of practice has affected me economically and professionally. I am living in a rural community and working at the local mental health clinic where clients wait 2 months to see a psychiatrist. Forty-nine percent of the residents in the valley are living in poverty.

I am willing to provide a deposition and have filed a grievance with the California state board.

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Yes- I did have restrictions placed upon my practice in Maine. I had been a practicing CNS for 8 years when I moved to Maine from Nevada and was not allowed to practice as a CNS despite my years of experience, my educational preparation (MN and nearly completed with Ph.D.), and my desire to do nothing outside of the scope of a Registered nurse in the state of Maine (not requesting privileges to medically diagnose or prescribe). The practice act in the state of Maine for a CNS requires national certification in addition to masters or Ph.D. education but does not grant any additional scope of practice. My

original education was as a critical care CNS and adult nurse practitioner. My CNS practice has been as a cardiovascular clinical nurse specialist across the continuum. Because I ended up taking the Adult Critical Care CNS exam offered by AACN, my license issued by the state restricts me legally to only this practice and title. This is ludicrous....by their interpretation, I could be disciplined for teaching on primary cardiovascular disease prevention or congenital heart defects because they are not strictly adult critical care concepts. I appreciate NACNS's efforts on our behalf and would be happy to speak to anyone further on this. Thank you-

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I am a CNS by profession and education who is currently working as an oncology CNS at United Hospital in St. Paul, MN. Our state Board of Nursing, in its wisdom, decided approximately 18 months ago that all CNSs must have CNS certification to practice as and carry the title of CNS. They noted that they would consider specialty tests other than the med-surg and critical care if it met their criteria (which I have never seen).

The Oncology Nursing Society has an advanced oncology nursing certification (AOCN) which many oncology CNSs have taken. Our Board of Nursing in Minnesota decided that our test did not meet the criteria since it did not definitively state CNS status when passing the test, and that the test was not exclusive to the CNS - other APRNs can take the test. The test blueprint, however, does cover almost exactly, the literature definition and the job description of a CNS. The Board would not relent.

We were then offered a waiver, if we met certain criteria and our specialty did not have an approved CNS exam. I, and many of my colleagues, met every point of the waiver criteria, but were denied anyway because "oncology fell under med-surg" and that test was available. No matter what our argument about med-surg certification not certifying us as specialist in oncology, they would not give in. I should note that this same argument fell upon the waivers of most of my colleagues in other specialties also.

As a consequence, most of the CNSs in Minnesota have had to take or will be taking the CNS med-surg certification exam in order to continue to hold the title and to practice as a CNS in Minnesota. Others have decided to return to school and work toward a NP certification. Neither choice is true to our profession, our specialty, and our very soul of practice as a CNS.

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I have experienced barriers to practice as a CNS in the state of Missouri. In 1992, I graduated from an approved CNS program in the state of Missouri, at that time no additional certification was required to practice as a CNS. I immediately began to practice as a CNS in pulmonary care, and maintained this position for 2 years before moving to Indiana. After moving, I obtained a pulmonary CNS position at a hospital in southern Indiana. I was privileged to serve in this role for 7 years with no barriers, until being transferred back to Missouri.

Upon my return to Missouri, I promptly renewed my RN license in 2001, and accepted a position as a nurse manager after I was unable to find a position as a CNS (due to lack of positions, not due to the certification requirements).
When completing paperwork for my 2003-2005 license renewal, I was surprised to notice that in order to call myself a CNS, I not only had to take a certification exam, but then had to be "recognized" by the state of Missouri before I could rightfully call myself a CNS in the state where just 10 years ago I could practice as a CNS. I spoke with a member of the board, who verified that this was the case, and that in the 7 years I was in Indiana the regulatory requirements for the state of Missouri had changed. Now I cannot obtain a CNS position due to requirements, not because of lack of positions.

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In N.C., The State Board of Nursing has a joint practice board with physicians, and advanced practice nurses serving on that board. There is not however, legislation that gives title protection or title recognition to advanced practice nurses who are not N.P's. Therefore, anyone can call themselves a Clinical Nurse Specialist who has had a lot of experience (and sometimes not so much) in a specialty area. At the University of North Carolina Hospital in 1998-99, and 2000, I know of a BSN prepared nurse who was called "CNS" because of her expertise in the area of cardiology. There is a difference in pay between the NP and the CNS (with a masters) who is in an advanced practice role in many parts/institutions of N.C. The rationale I have heard given is that there is no way of "knowing" their competence. At one time the UNC School of Nursing offered a CNS in their graduate program but it was dropped sometime in the 90's. Have I personnally suffered economic harm? again, that depends on the perspective of how you look at being denied reimbursement for your practice and others "claiming" to be a CNS without having gone to graduate school who are receiving compensation at a commensurate level.

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I am a licensed CNS in California (for 5 years) which based its CNS license on the NACNS criteria. I recently relocated to Ohio and in order to be licensed & practice as a CNS in Ohio I am studying for the AOCN (onwe of the specialty exams recognized in Ohio for certification as a CNS. I have an OCN. My job here is called a Care Coordinator. It's a new position so I have been applying the NACNS criteria to the position and essentially have been functioning as a CNS. I miss not being able to practice as an authentic CNS as I did in California.
1) Because of licensing structure in Ohio I am being denied being able to use the title CNS in Ohio.
2) I could not negotiate my salary from the CNS position because in Ohio I am not licensed as a CNS but have been for 5 years in California
3) I am now preparing to take the AOCN exam in October so I can qualify to apply for the CNS license in Ohio.

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Finally!!!
I graduated from Angelo State University (San Angelo, TX) August 1998. Two days prior to graduation, the four of us who were in the Maternal-child Health CNS MSN were told we were not eligible for CNS status. Previously we were told that due to the lack of masters level certification exam we would be grandfathered as CNS's. We were the first and last class in the MCH speciality. ASU continues to educate med/surg CNS's. We appalled to the Texas BON with no avail. We were told we would need an additional 400 clinical hours (I already had close to 800), however they would not approve a preceptor as we would not be able to sit for boards. We appealed to the University due to the expense--no avail. I subsequently moved to New Mexico--no luck here either. Have since taken an additional 8 graduate hours towards a FNP--however stopped as Family is not my area---adults especially. I am now teaching nursing full time--but I want that piece of paper! I graduated with a 4.0/49 hours. Have a 4.0 in the subsequent classes. One of the additional courses I took for the FNP was pharmacotherapeutics (even though I made an A in the class for my masters)--just in case something changed and I would be more current.

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I have been a CNS since 1989. I have practiced both in the civilian arena and as an Active Duty Officer in the United States Army. The US Army had identified me as a 7T which is the identifier for a CNS. In 2002, I retired from the Army and settled in Texas. I attempted to obtain the licensing as a CNS in the state of Texas and was denied. Apparently, while I was stationed overseas serving my country, I did not meet the deadline to be grandfathered in to practice in Texas. According to the board of nursing in Texas, I need to take at least three courses. In other words, I can not identify myself as a CNS despite the fact the United States Army did so in 1995 (after a lengthy application process which included transcripts, etc). I have been offered a position as a CNS in another state but my husband and elementary aged child really do not want to leave their life. I think they had enough of moving while I was in the Army. Also, I don't want to take a position and be separated from my family which I have done in the past while being Active Duty. In order to meet the needs of the state, I will have to take an advanced pharmacology class to obtain prescriptive authority which I do not want and will not use. I have practiced quite successfully as a CNS in California and in the US Army for the last 14 years and now must quit doing so because the board in the State of Texas does not recognize me as an expert despite my Master's Degree in Nursing and my previous positions? I have held national certification in two areas in the past (I am not presently) because I was overseas and could not take the recertification. I would be happy to provide a deposition and what ever else I can to to support your efforts.

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Greetings from Angelo State University! I am the head of the Department of Nursing here at ASU. We offer a MSN that prepares individuals to take the certification exam for Medical-Surgical Clinical Nurse Specialist. However, we had implemented a Parent-Child MSN which focused on the expectant family and the child up to one year of age back in 1998 (the same year as we implemented the Adult Health program). We had five

students graduate from the maternal-child track. We had to close that program after the first class graduated because the Board of Nurse Examiners for the State of Texas said they would not approve the program, and would not recognize our parent-child graduates as Clinical Nurse Specialists because there was no national certifying exam for this major. Those first graduates could not seek a waiver for that rule because our program was not NLN-accredited because, as you know, you can't seek NLN accreditation until you graduate your first class. I felt terrible for those students, they tried for several years to get CNS recognition but to no avail.
We closed the program as there was no student interest once they found out they couldn't be recognized as a CNS. Unfortunately, it has become so difficult to find maternal-child faculty because there are so few programs offering that specialization. One of my colleagues at the University of Texas at Austin wrote me to tell me they will be starting a Parent-Child track in the fall but the title they are using is "Parent-Child Nurse Clinician" because of the certifying exam problem. I would love to resurrect our program but students are really turned off because of the certifying issue.
I appreciate your efforts to address this problem.

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I was forwarded the letter about CNS and certification exams. That is exactly what is happening here in Texas. The Texas BNE requires a certification exam in order for newly graduated CNS to be able to have or use the title. There is no certification exam for maternal child or perinatal and the test-creating organizations have told us that there are too few in this specialty for them to make money. They will not create a certification exam. UT Houston continues their perinatal CNS program by requesting a waiver every year from the BNE which the BNE grants. But new programs are not permitted to be waivered since they are not yet accredited until AFTER their first students graduate. This is what happened to us at Angelo State University. Our maternal child master's students could not become CNS, and we shut down the program.

The upshot is that there are few CNS in perinatal or maternal child. This means that we cannot find OB faculty because prospective students with OB backgrounds cannot find programs to meet their needs. Either that or they get their CNS in med-surg instead. I've been told that there is a national shortage of OB faculty. We certainly can't find any here!

Another result is that the perinatal care here in Central West Texas could desperately use an infusion of energetic talented nurses to implement new practices and integrate new research (or just standards of care!) into practice. With no program, there are no talented advanced practice folks in OB or perinatal care. Quality of care definitely suffers here.

Let me know if there is anything I can do to help. I teach at Angelo State University and we'd love to re-start our maternal child CNS program. We'd probably do it the minute they drop the barrier of requiring a certification exam.

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As an educator in a school of nursing and as a consultant for an educational company, my training as a clinical nurse specialist through the course work and clinicals during my program make me very effective in teaching students and nurses. My expertise has influenced the care of hundreds of patients through the courses I offer. Because of the restrictions in the law within the State of Ohio, I have not taken the specialty exam for adult health because I do not see patients directly and I do not have, or need, a consulting physician. Because of my training, I should be able to call myself a CNS because of the degree I hold. The title CNS reflects on my credibility and expertise.

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I have not yet experienced financial harm related to the examination requirements, however, I am not convinced that this issue will not arise in the future. I studied to be a CNS in the early 1980's, became certified with a test that was available at the time and have maintained certification ever since. Now, I am required to take another test, which does not exist for maternal-child health. I offered to test in homecare, as many of my advance practice clinicals for schools were located in the community settings. The testing agency did not allow that because clinicals do not show up on my transcript from 20+ years ago. I saw the sample homecare test questions and know that about half of them deal with maternal-child health. A perfect fit. Other questions dealt with social services, community planning and education etc. Sounds like the topics I studied, but not through the school of public health. Anyway, now I have to prove I had supervised hours of practice after I finished school. Well, those were not required then; that doesn't mean they were not done, it means they were not recorded. It's hard to go and reconstruct this stuff, and find someone to sign it for you.
I thought I was doing something beneficial for my patients and myself be furthering my education. These days it seems like just another hassle to deal with. And, this hassle is not helping me serve my patients. It takes time away to prove to another generation of people how I tried to better myself 20+ years ago.

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In response to your CNS Alert regarding economic harm due to regulatory barriers, I would like to submit the following description regarding my situation. While it does not exactly fall into the barriers you have listed, my experience does pertain to a regulatory barrier, especially in regards to Psychiatric Clinical Nurse Specialists in the state of Arizona.

I was certified by ACNN as a Clinical Nurse Specialist in Child and Adolescent Psychiatric and Mental Health Nursing (APRN, BC) a few years after receiving my MS in Nursing from the University of Arizona in 1980. In 2002 I became certified by the Arizona State Board of Nursing in Advanced and Extended Nursing Practice as a Clinical Nurse Specialist. I do note that the State of Arizona Nurse Practice Act R4-19-511 in it’s Requirements for Clinical Nurse Specialist Certification states that the applicant for certification "Have evidence of current certification by a national nursing credentialing agency in a clinical area of nursing practice”. While this was not a problem for me, it

could be for other Master prepared nurses who wish to obtain Clinical Nurse Specialist certification and practice as an Advanced Nurse Practitioner in the State of Arizona.

My specific experience pertains to the fact that I cannot be registered as a provider in The Arizona Health Care Cost Containment System (AHCCCS) which is the State of Arizona's Medicaid program. Currently AHCCCS only registers M.D.'s, D.O's., Registered Nurse Practitioners, Nurse-Midwives, Certified Registered Nurse Anesthetists, Podiatrists, Dentist and other Non-Physician Specialties such as Psychologists and MSW Social Workers. Because I cannot be registered, I cannot use 9000 codes to bill for services and cannot contract independently to treat Medicaid members. This is in spite of the fact that I am state certified as an Advanced Practice Nurse and R4-19-512 allows me to perform "psychotherapy, by clinical nurse specialists with expertise in adult, or child and adolescent psychiatric and mental health nursing."

I am also classified a Behavioral Health Professional by the State of Arizona Division of Behavioral Health only because I meet the qualifications of a Registered Nurse with one year experience in Psychiatric Nursing. Once again the Clinical Nurse Specialist certification is discounted.

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The District of Columbia Board of Nursing is requiring an Advanced Registered Nurse Specialty license for Clinical Nurse Specialists to call themselves CNS. It requires a graduate level (3 credit) pharmacology course, with continuing education credits after initial licensure for all nurses to be licensed as a CNS. Perinatal CNSs' do not have prescriptive authority. In addition, they require certification from a "nationally recognized accrediting body accepted by the Board, i.e., American Academy of Nurse Practitioners, American Nurses Credentialing Center".

I am a Perinatal CNS by education and have an APN certificate from the U of MD, am certified by NCC in Inpatient Obstetrics. I am currently working as an "educator" and took a pay cut in this new job.

I am a member of NACNS.

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I am an RN, MS, CWOCN and CNS in Illinois. In the Midwest it is difficult to obtain an MSN because the availability of schools, the travel distance and the availability of the programs. I did however obtain a Masters degree from an Illinois University as well as obtain specialized training to become certified as a wound, ostomy, continence nurse. I have been certified as a WOCN since 1999. In the state of Illinois, to obtain a CNS license, it is also required for the RN to carry a duel license, which I obtained in July, 2001.

I feel that the barrier for the classification of the Clinical Nurse Specialist has many insurmountable barriers. Not only do I have to pay the extra fees for the duel license, but also the acute care facility where I am employed, has never acknowledged my license

even though they have them on file. To maintain my CNS license and my certification for WOC, I am required too have 240 professional growth points over the 5 year certification period for WOC, and 50 hours of continuing education of continuing education every 2 years to maintain my CNS license. To add further classes, which I would not use, would add to the financial burden that I already have.

On June 2, 2003 my position as a CWOCN was eliminated. I feel that this occurred because there was no reimbursement for the WOC service. I have been able to maintain employment at the same facility, but it is not in the job for which I am certified. My only other course was to relocate to another area to continue to work in my specialty area.

The areas of wound, ostomy, and continence are a much-needed service in the healthcare industry. Without these services the problems in increased pressure ulcers and incontinence problems will continue to grow. Pressure Ulcers has been focused as a Sentinel Event in the year 2004. The expectation, at my facility, is that RNs need to handle these problems and should be able to identify and treat the patient's problems. If they are unable to comply this will mean that the prevalence and incidence of these problems will continue to escalate. Without the recognition as a Clinical Nurse Specialist the positions for wound, ostomy and continence will continue to disappear and a service that is now available will also disappear thus denying the public access to needed services. There needs to be a level of regulation for CNS without prescriptive authority which will help assure that CNSs would meet requirements of 3rd party payers to allow for reimbursement of CNS services.

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I am a rehabilitation CNS. Our organization, ARN, has credentialing for Advanced Practice Nurses which is not recognized by the Credentialing Center. Therefore, if I want advanced certification I must go to another area, e.g. Med/surg CNS,etc which does not reflect rehabiltation nursing practice. ARN is the leader for setting standards of practice for rehabilitation nursing and has a strong, excellent standing in the nursing community and should be recognized as the body to certify rehabilitation advanced practice nurses.

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I graduated from a masters program from Loyola University in the late 1970's as a Clinical Nurse Specialist in medical surgical nursing with a specialty in Neuroscience. Initially I was able to call myself a Clinical Nurse Specialist. Eventually that title was taken away from me and now can only refer to myself as a Clinical Consultant in Neuroscience. I firmly believe that this confuses this confuses the patients who see my title on badge, it is confusing for the physicians, who are used to Clinical Specialists and Nurse Practitioners but not Clinical Consultants. In addition I believe that it reduces my chances for appropriate raises. I do the work of a Clinical Nurse Specialist, but cannot call myself one. I have taken and passed the nationally accredited CNRN exam in my area of specialty but this still does not allow me to call myself a Clinical Specialist.