

**REPORT OF THE  
JOINT COMMISSION ON HEALTH CARE**

**Prescriptive Authority of  
Physician Assistants  
(HB 2318, 2001)**

**TO THE GOVERNOR AND  
THE GENERAL ASSEMBLY OF VIRGINIA**



**HOUSE DOCUMENT NO. 29**

**COMMONWEALTH OF VIRGINIA  
RICHMOND  
2005**





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*Joint Commission on Health Care*

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March 15, 2005

**TO:** The Honorable Mark R. Warner, Governor of Virginia  
and Members of the General Assembly

The 2001 General Assembly, in enacting House Bill 2318, expanded the prescriptive authority for physician assistants from Schedule VI to Schedules IV through VI drugs. The 2003 General Assembly enacted House Bill 2205 which expanded prescriptive authority for physician assistants further to include Schedule III controlled substances beginning July 1, 2004.

An enactment clause, within House Bill 2318, required the Joint Commission on Health Care (JCHC) to study the impact of the changes in prescriptive authority. An interim report was submitted in July 2004, and an executive summary of the final report was submitted prior to the 2005 General Assembly Session. Based on report findings, the Joint Commission voted not to take further legislative action.

The final JCHC report on prescriptive authority for physician assistants is enclosed for your consideration.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "H. B. Morgan".

Harvey B. Morgan



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# JOINT COMMISSION ON HEALTH CARE: 2004

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The Honorable Harvey B. Morgan

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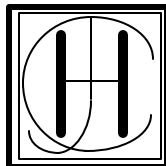
## **Secretary of Health and Human Resources**

The Honorable Jane H. Woods

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## **Executive Director**

Kim Snead





## **PREFACE**

House Bill 2318, of the 2001 Session of the General Assembly, expanded the prescriptive authority for physician assistants from Schedule VI to Schedules IV through VI drugs. The 2003 General Assembly enacted House Bill 2205 which expanded prescriptive authority further to allow physician assistants to prescribe Schedule III controlled substances beginning July 1, 2004.

An enactment clause, within House Bill 2318, required the Joint Commission on Health Care (JCHC) to study the impact of the changes in prescriptive authority. The JCHC study determined that the number of physician assistants in Virginia increased by more than 90 percent between 1999 and late-March 2004 and that a large majority of the licensed physician assistants had prescriptive authority. Research has shown that quality care is provided by physician assistants and that patient satisfaction with that care is generally high.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the American Academy of Physician Assistants, the Board of Medicine, the Bureau of Insurance, the Department of Health, the Department of Health Professions, the Eastern Virginia Medical School Library, the Medical Society of Virginia, the Old Dominion Medical Society, and the Virginia Association of Health Plans for their assistance in the completion of this study.

Kim Snead  
Executive Director

March 2005





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# **PRESCRIPTIVE AUTHORITY OF PHYSICIAN ASSISTANTS**

## **EXECUTIVE SUMMARY**

### **Authority for Study**

House Bill 2318 (HB 2318) of the 2001 General Assembly Session expanded the prescriptive authority for physician assistants (PAs). Specifically, the prescriptive authority for PAs changed from the authority to prescribe only Schedule VI drugs to a time table (over a period of several years) for the authority to prescribe Schedules IV-VI drugs. An enactment clause in HB 2318 required the Joint Commission on Health Care to provide a report on the issue of prescriptive authority for PAs prior to the 2005 General Assembly Session. Specifically, the Commission is required by the enactment clause:

...to study physician assistant prescriptive authority as provided in this act to determine the impact of the authority to prescribe Schedules IV through VI controlled substances and devices on patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction with physician assistant treatment.

It should be noted that House Bill 2205 (HB 2205) of the 2003 General Assembly Session also expanded the prescriptive authority of PAs. HB 2205 provided PAs with the authority to prescribe Schedule III controlled substances on or after July 1, 2004.

### **Growth in the Number of Physician Assistants**

The number of PAs in Virginia has increased more than 90 percent between 1999 and late-March 2004. As of late-March 2004, there were 957 licensed PAs in Virginia. The number of PAs with prescriptive authority was 697, appearing that almost 73 percent of PAs have prescriptive authority. Because only 771 of the 957 licensed PAs are engaged in active practice, the number of eligible PAs with prescriptive authority would actually be closer to 90 percent.

### **Virginia Data on Physician Assistants**

The Board of Medicine (BOM) collects some information about its licensees including PAs and their practice locations. Having information regarding the practice location of PAs allows a comparison to the primary care health professional shortage areas (HPSAs). JCHC staff compared the PA addresses that were provided to the BOM with the primary care HPSAs. This

comparison of data found that 94 records or 9.9 percent of records listed work addresses that were found to be in designated primary care HPSAs. (Analysis of 950 of 989 PA records listing a Virginia address were matched to a census tract). Seventy-two records or about 7.6 percent of records of PAs with prescriptive authority listing a Virginia address listed addresses that were found to be in primary care HPSAs.

Information concerning PA primary practice specialty is not collected. This information would be useful in comparing the locations in which PAs practice, the practice locations that are within a HPSA, and the practice specialties that are represented.

### **Information on Other States**

Three states allow no prescriptive authority for PAs; Ohio, Louisiana, and Indiana. Twenty-eight states allow PAs to prescribe up to Schedule II controlled substances with physician involvement (although some states may have restrictions and/or formularies). Eleven states allow PAs to prescribe drugs through Schedule III controlled substances (although some states may have restrictions and/or formularies). A small number of states allow prescription of the lower schedules of controlled substances, a formulary of authorized drugs, or non-controlled substances.

At the time of this study, Virginia was in the mid-range of the level of prescriptive authority allowed to PAs in comparison to other states, but moved up by authorizing as of July 1, 2004, PAs to prescribe Schedule III through VI controlled substances. The level of supervision required for PAs varies widely between states. Although some states require direct, on-site supervision, most do not. Other states allow for supervisory contact via some type of telecommunication. There are also stipulations in some states for chart review or cosigning within a variety of time-periods. Virginia requires continuous supervision, but the physician does not have to be physically present at all times.

### **Mandated Areas of Study**

With regard to areas mandated for study, JCHC staff found:

- A number of studies conducted in the United States have shown that quality care is being provided by PAs. Moreover, it is likely that the increase in PA prescriptive authority in Virginia has had a positive impact on patient care.

- The research on provider relationships is ambiguous; making further extrapolation to the impact increased PA prescriptive authority has had on provider relationships difficult.
- Reimbursement of PA services depends on the category of payer. Currently, under the Virginia Medicaid program, PAs do not receive direct reimbursement.
- The impact that the increase in PA prescriptive authority has had on physician practices is closely tied with other previous categories (for instance, physician practices are impacted by provider relationships). Physicians in practice were impacted in their day-to-day operations if they employed PAs when the PA prescriptive authority increased. Some individuals contacted as part of the study indicated that the prescriptive authority was beneficial to physicians and PAs in that it reduced some burdens. Some of these decreases in burdens likely increased the efficiency of some physician practices.

A number of studies indicated that patient satisfaction exists with PA services generally. In addition, anecdotal evidence suggested that patient satisfaction with regard to PA prescriptive authority was high.

### **Actions Taken by JCHC**

Three policy options were offered for consideration by the Joint Commission on Health Care. On November 15, 2004, the Commission voted to take no action.



## **I. Authority for the Study/Organization of Report**

House Bill 2318 (HB 2318) of the 2001 General Assembly Session expanded the prescriptive authority of physician assistants. Specifically, the prescriptive authority for physician assistants changed from the authority to prescribe only Schedule VI drugs to a time table (over a period of several years) for the authority to prescribe Schedules IV-VI drugs. The bill also removed the requirement that the Board of Medicine develop a formulary of the drugs that physician assistants were authorized to prescribe. This provision was changed to require the supervising physician or podiatrist and the physician assistant to develop a written agreement that lists the drugs that the physician assistant is or is not allowed to prescribe.

In addition, an enactment clause in HB 2318 required the Joint Commission on Health Care to provide a preliminary report on the issue of prescriptive authority for physician assistants by July 1, 2004 and a final report on the issue prior to the 2005 General Assembly Session. Specifically, the Commission is required by the enactment clause:

to study physician assistant prescriptive authority as provided in this act to determine the impact of the authority to prescribe Schedules IV through VI controlled substances and devices on patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction with physician assistant treatment.

HB 2318, as passed by the General Assembly and approved by the Governor, became effective on July 1, 2001. A copy of the bill is provided in Appendix A.

It should be noted that House Bill 2205 (HB 2205) of the 2003 General Assembly Session also expanded the prescriptive authority of physician assistants. HB 2205 provided physician assistants with the authority to prescribe Schedule III controlled substances on or after July 1, 2004. Although the provisions of HB 2205 will be enacted after the completion of this study, it is important to recognize this change which will provide physician assistants with the same level of prescriptive authority as nurse practitioners in Virginia.

## **ORGANIZATION OF THE REPORT**

This report includes three major sections. This section discussed the authority for the study. Section II presents background information on physician assistants in Virginia and includes a discussion of the laws and regulations governing physician assistants and their ability to have prescriptive authority. Section III will discuss issues related to physician assistant prescriptive authority as provided in HB 2318, an overview of data collected by the Board of Medicine, and a brief examination of physician assistant prescriptive authority in other states.



## **II. Background**

Physician assistant (PA) programs were established in response to concerns regarding the supply and accessibility of practicing physicians. The first PA program was started at Duke University Medical Center in 1965 by Dr. Eugene Stead. According to the American Academy of Physician Assistants (AAPA), Dr. Stead established Duke University's PA program by:

select[ing] Navy corpsmen who received considerable medical training during their military service and during the war in Vietnam but who had no comparable civilian employment. He based the curriculum of the PA program in part on his knowledge of the fast-track training of doctors during World War II.

Since that time, there has been a growth in the number of accredited educational programs for PAs and practicing graduates of PA programs. Currently, there are 133 accredited PA programs (four in Virginia) and approximately 50,121 PAs in clinical practice. In 2003 alone, there were 4,415 graduates from PA programs.

With the aging of the United States population, there is an increasing demand for health care providers. In Virginia, there are also issues of adequacy of services in communities that do not have adequate access to primary care. Some research has concluded that providing appropriate access to primary care will require the increased use of physician extenders such as nurse practitioners and physician assistants. This study focuses on the prescriptive authority of PAs which some see as a necessary provision in providing increased access to health care for individuals, especially in medically underserved areas. Specifically, the following sections provide an overview of PAs in Virginia and the laws and regulations that govern them.

### **OVERVIEW OF PHYSICIAN ASSISTANTS IN VIRGINIA**

The sections that follow provide descriptive information regarding the number of physician assistants licensed in Virginia as well as the number of physician assistants that have prescriptive authority. Some additional background information is provided regarding other general characteristics of PAs in this state.

## **Growth in the Number of Physician Assistants in Virginia Has Been Substantial**

The number of physician assistants in Virginia has grown substantially in the last six years. For instance, between 1999 and 2004 the number of licensed PAs in Virginia increased by over 90 percent. As of March 23, 2004, there were approximately 957 licensed physician assistants in Virginia. Figure 1 illustrates the growth in the number of physician assistants during this time period.

Growth in the number of PAs was also experienced at the national level. The number of PAs in the nation grew from 41,421 (according to the AAPA, those believed to be eligible to practice as PAs) in 1999 to 57,879 in 2003, an increase of 40 percent. Therefore, it would appear that PAs are becoming more prevalent in the medical workforce in both the nation and Virginia. The growth in the number of PAs may also be partly due to the increase in their authority, such as being authorized to prescribe an increasing number of medications in many states.

## **An Increasing Number of Physician Assistants Have Prescriptive Authority**

A similar historical trend has developed for the number of PAs that have prescriptive authority. Again, Figure 1 provides a historical trend for PA prescriptive authority between 1999 and 2004. During this six-year period, PA prescriptive authority increased from 12 PAs with prescriptive authority in 1999 (2.4 percent of licensed PAs) to 697 PAs with prescriptive authority as of late-March 2004 (72.8 percent of licensed PAs). However, the current percentage of 72.8 PAs with prescriptive authority actually underestimates the percentage of physician assistants that have prescriptive authority. This is due to the fact not all licensed PAs are engaged in active practice. Of the 957 licensed PAs, only 771

<b>Figure 1</b>						
<b>The Number of Licensed Physician Assistants Licensed in Virginia in 1999 and 2003</b>						
<b>Category of Physician Assistants:</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Licensed Physician Assistants*	501	602	723	804	903	957
Licensed Physician Assistants with Prescriptive Authority	12	185	397	540	572	697
Percentage of Physician Assistants with Prescriptive Authority	2.4%	30.7%	54.9%	67.2%	63.3%	72.8%
Source: <i>Data provided by the Board of Medicine on March 23, 2004, Department of Health Professions, 2004.</i>						
Note: * Not all licensed PAs are actively practicing.						

are actively practicing, which then enables them to be eligible for prescriptive authority. Therefore, the percentage of eligible physician assistants with prescriptive authority would actually be closer to 90 percent. It appears that a large percentage of PAs are taking advantage of the ability to prescribe controlled substances.

Figure 2 provides an accounting of the number of PAs within each level of prescriptive authority, according to data provided by the Board of Medicine (BOM). About 36 percent of PAs have the authority to prescribe Schedule IV controlled substances and about 66 percent have the authority to prescribe Schedule V controlled substances. Again, it should be noted that House Bill 2205 (HB 2205) of the 2003 General Assembly Session will enable physician assistants to prescribe Schedule III controlled substances beginning July 1, 2004.

<b>Figure 2</b>			
<b>Categories of Prescriptive Authority in FY 2004</b>			
<b>Drug Schedule</b>	<b>IV</b>	<b>V</b>	<b>VI</b>
Number of PAs with Prescriptive Authority*	252	460	660*
Source: <i>Data provided by the Board of Medicine on March 23, 2004, Department of Health Professions, 2004.</i> Note: *Although the data indicated that 697 PAs had prescriptive authority as of March 23, 2004; the data contained records where the level of prescriptive authority was unknown as well as other instances where it was likely that a PA had level VI authority but it was not listed.			

### **Most Physician Assistants Are in Clinical Practice**

A survey conducted by the AAPA in 2003 found that 99.2 percent of survey respondents from Virginia were in clinical practice. (There were 363 respondents for this survey question.) Approximately 40 percent of the total number of PAs licensed in Virginia in 2003 responded to the AAPA survey. The most common job settings of the 351 responding PAs included physician's practices at 65.3 percent and hospitals at 17.4 percent.

Figure 3 provides an overview of the areas of practice reported by PAs in Virginia in response to the 2003 AAPA survey. For example, the largest category of reported practice areas in Virginia was that of family/general medicine at 27.9 percent, followed by surgical subspecialties at 23.4 percent. The percentage of Virginia respondents reporting their primary specialty in one of the primary care fields was about 35.5 percent (those specialties that are bolded in Figure 3). This compared to about 44 percent of national respondents reporting their primary specialty as a primary care area.

**Figure 3**  
**Categories and Numbers of Physician Assistants**  
**in Virginia by Practice Specialty**

<b>Category:</b>	<b>Number of PAs</b>	<b>% of Total Respondents</b>
<b>Family/general medicine</b>	<b>99</b>	<b>27.9%</b>
Surgical subspecialties	83	23.4%
Emergency medicine	59	16.6%
Internal medicine subspecialties	36	10.1%
Other	30	8.5%
<b>General internal medicine</b>	<b>20</b>	<b>5.6%</b>
Industrial/occupational medicine	11	3.1%
General Surgery	10	2.8%
<b>Obstetrics and gynecology</b>	<b>5</b>	<b>1.4%</b>
<b>General pediatrics</b>	<b>2</b>	<b>0.6%</b>
Pediatric subspecialties	0	0%
<b>Total</b>	<b>355*</b>	<b>100%</b>

Source: 2003 AAPA Physician Assistant Census Report, American Academy of Physician Assistants, 2003.

Note: The primary specialty areas that are considered to be primary care categories by the AAPA are shown in bold text.

\* This number represents the number of respondents to a particular question of the AAPA census survey in 2003 and represents approximately 40 percent of the population of licensed physician assistants in Virginia for 2003.

## **VIRGINIA LAWS AND REGULATIONS GOVERNING PHYSICIAN ASSISTANTS**

The following sections provide an overview of the laws and regulations governing the general licensure of physician assistants and the requirements to obtain prescriptive authority in Virginia. In both cases, the Board of Medicine develops regulations for PAs, with consultation from the Board of Pharmacy concerning the regulations pertaining to prescriptive authority.

### **Laws and Regulations Governing the Licensure of Physician Assistants in Virginia**

The following sections provide an overview of the laws and regulations governing physician assistant practice in Virginia. These sections will highlight some of the more important stipulations related to PA licensure.

**Section 54.1 of the Code of Virginia contains stipulations on physician assistant licensure.** The authority to license PAs is provided under Title 54.1 of the *Code of Virginia*. Stipulations concerning PAs can be found mainly between § 54.1-2949 and § 54.1-2953. These sections mandate that the Board of Medicine develop regulations for the licensure of physician assistants with certain requirements in mind. Also, these sections of the *Code* provide the authority to issue provisional licenses to PAs who have completed an approved educational program but not the required examination, until the next examination for PAs is conducted by the National Commission for Certification of Physician Assistants (NCCPA), and to issue restricted volunteer licenses (those practicing in free clinics, without receiving compensation, etc.). Finally, the regulations also provide guidance on the supervision of assistants by physicians and PA prescriptive authority (which will be discussed in detail in the following section).

**Title 18, 85-50-10 through 85-50-160 of the Virginia Administrative Code prescribes requirements on PA licensure and practice.** These regulations mandate requirements concerning the following: general requirements, licensure requirements, provisional licensure, license renewal, discontinuation of employment, inactive licensure, registration of voluntary practice by out-of-state licensees, protocol requirements, supervisor responsibilities, PA responsibilities, volunteer restricted licensure, qualifications for prescriptive authority, approved drugs and devices, protocol requirements concerning prescriptive authority, and disclosure. While this report will not go into detail about all of these sections, it is important to review several of them to provide background information on the requirements to be a physician assistant. Also, the requirements concerning prescriptive authority will be discussed in the proceeding sections.

VAC Title 18, Section 85-50-50 discusses the requirements for initial licensure. The following provisions are the requirements for application for licensure as a physician assistant:

1. A completed application and fee as prescribed by the board.
2. Documentation of successful completion of an educational program as prescribed in §54.1-2951.1 of the *Code of Virginia*.
3. Documentation of passage of the certifying examination administered by the National Commission on Certification of Physician Assistants.
4. Documentation that the applicant has not had a license or certification as a physician assistant suspended or revoked and is not the subject of any disciplinary proceedings in another jurisdiction.

While the requirements for initial licensure are mostly self-explanatory, several of the provisions need further explanation.

The second requirement for initial licensure (85-50-50), as previously mentioned above, is to complete an educational program as specified in § 54.1-2951.1 of the *Code of Virginia*. This provision requires, “Successful completion of a physician assistant program or surgeon assistant program accredited by the American Medical Association or a committee of the American Medical Association established to approve or accredit allied health education programs...”. PAs must complete an accredited educational program to be eligible for licensure in Virginia. Currently, there are four accredited PA programs in Virginia.

The third requirement for initial licensure is to have professional certification through passage of an examination. While it is necessary to meet this requirement, a provisional license may be issued to applicants that have met the other requirements until the next examination administered by the NCCPA. The NCCPA describes its purpose and mission as the following:

NCCPA is the only credentialing organization for physician assistants in the United States. Established as a not-for-profit organization in 1975, NCCPA is dedicated to assuring the public that certified physician assistants meet established standards of knowledge and clinical skills upon entry into practice and throughout their careers. Every U.S. state, the District of Columbia and the U.S. territories rely on NCCPA certification criteria for licensure or regulation of physician assistants. Approximately 50,000 physician assistants have been certified by NCCPA.

VAC Title 18, Section 85-50-56 includes requirements for licensure renewal. To renew their license, PAs must renew biennially and verify, “compliance with continuing medical education standards established by the NCCPA.” This essentially means having to receive 100 hours of continuing medical education every two years.

Responsibilities related to the physicians who supervise PAs are delineated in VAC Title 18, Section 85-50-110. The regulations address the following: (1) requirements for physicians to see patients who have unresolved complaints and/or continuing illness and how often these patients will be seen by a physician, (2) the invasive procedures that may and may not be performed by a PA, (3) a requirement for a physician to witness a PA performing an invasive procedure at least three times prior to the assistant being able to perform the procedure by himself or herself, and (4) a requirement for the physician to specify the procedures that the PA can perform in writing to the Board (including how many times the PA has performed the procedure under the physician’s supervision). Additionally, Virginia regulations have been interpreted to require continuous supervision of the PA by the physician but not that the physician be physically present at all times. (Although not mentioned in

the regulations specifically, the *Code of Virginia* mandates that physicians cannot supervise more than two physician assistants at one time.)

VAC Title 18, Section 85-50-101 includes the requirement that PAs and their supervising physician have a written protocol that “spells out the roles and functions of the assistant.” The protocol:

“... shall take into account such factors as the physician assistant's level of competence, the number of patients, the types of illness treated by the physician, the nature of the treatment, special procedures, and the nature of the physician availability in ensuring direct physician involvement at an early stage and regularly thereafter.”

Additionally, the protocol is required to delineate the evaluation process of the PA, spell out the level of supervision for given tasks, and include which controlled substances the PA is allowed to prescribe.

### **Laws and Regulations Governing Prescriptive Authority of Physician Assistants in Virginia**

The following sections provide an overview of the laws and regulations governing prescriptive authority of physician assistants in Virginia. These sections will highlight some of the more important stipulations related to PA prescriptive authority.

***Section 54.1 of the Code of Virginia contains stipulations on physician assistant prescriptive authority.*** Specifically, § 54-2952.1 of the *Code*, requires the Board of Medicine (BOM) “in consultation with the Board of Pharmacy” to promulgate regulations regarding prescriptive authority for PAs. This section of the *Code* addresses the prescription of “certain controlled substances and devices by licensed physician assistant” as well as other stipulations related to this authority. For example, within this *Code* section, the timetable of when physician assistants become eligible to prescribe certain schedules of drugs is outlined. The following provides that timetable:

- (i) Schedules V and VI controlled substances on and after July 1, 2001,
- (ii) Schedules IV through VI controlled substances on and after January 1, 2003, and
- (iii) Schedule III through VI controlled substances on and after July 1, 2004.

(This schedule was altered by HB 2318 of the 2001 General Assembly Session and HB 2205 of the 2003 General Assembly Session). Figure 4 provides a brief description of Schedules I through VI. As noted above, PAs received authority to prescribe schedule IV drugs as of January 1, 2003. Physician assistants will not receive the authority to prescribe Schedule III drugs until July 1, 2004.

<b>Figure 4</b>
<b>Description of Schedules I through VI</b>
<b>Schedule I</b> - “high potential for abuse; and has no accepted medical use in treatment in the United States or lacks accepted safety for use in treatment under medical supervision.”
<b>Schedule II</b> - abuse of these controlled substances “may lead to severe psychic or physical dependence.”
<b>Schedule III</b> - abuse of these controlled substances “may lead to moderate or low physical dependence or high psychological dependence.” Example - certain anabolic steroids.
<b>Schedule IV</b> - abuse of these controlled substances “may lead to limited physical dependence or psychological dependence” relative to Schedule III. Example - Phenobarbital.
<b>Schedule V</b> - “limited physical dependence or psychological dependence liability” relative to Schedule IV. Example – Lomotil.
<b>Schedule VI</b> - basically all other controlled substances.
Source: Sections 54.1-3445 through 54.1-3455 of the <i>Code of Virginia</i> .

An additional stipulation under this section of the *Code* requires that a physician assistant enter into a written agreement with a licensed physician or podiatrist that governs which controlled substances the PA is authorized to prescribe and may include any restrictions that the supervising physician considers appropriate. The *Code* stipulates that physicians must make periodic site visits at locations that they do not regularly practice but where PAs provide services under their supervision. However, even though PAs are not required to have direct supervision of a physician at all times, PAs are not allowed to establish a separate office.

***Title 18, 85-50-130 through 85-50-160 of the Virginia Administrative Code imposes requirements for PA prescriptive authority.*** The regulations promulgated by BOM “in consultation with the Board of Pharmacy” governing PA prescriptive authority are included in Title 18, 85-50-130 through 85-50-160 of the *Virginia Administrative Code* and provide additional requirements for PAs. For example, the regulations include stipulations on obtaining approval for prescriptive authority, approved drugs and devices, the protocol concerning prescriptive authority, and PA disclosure requirements. The following paragraphs will explain some of the stipulated requirements for prescriptive authority in more detail.



For initial approval of prescriptive authority, the applicant must meet the following requirements:

1. Hold a current, unrestricted license as a physician assistant in the Commonwealth;
2. Submit a protocol acceptable to the board prescribed in 18VAC85-50-101. This protocol must be approved by the board prior to issuance of prescriptive authority;
3. Submit evidence of successful passing of the NCCPA exam; and
4. Submit evidence of successful completion of a minimum of 35 hours of acceptable training to the board in pharmacology.

Prescriptive authority is renewed biennially as part of the general PA license if the PA desires to have the authority. The protocol requirements for PA prescriptive authority are included as part of the general requirement protocol as well. If there are any changes in scope of practice, supervision, or authorized drugs, then a new protocol must be submitted.

As far as continuing education requirements, there are no additional stipulations under the prescriptive authority regulations. However, under the general requirements for PA licensure, PAs are required to meet NCCPA continuing medical education standards. Again, this mandates that PAs receive 100 hours of continuing medical education every two years, much of which involves pharmacotherapeutics.

A final area of importance that should be mentioned is the disclosure requirements for prescriptive authority. PAs are required to tell patients that they are PAs and “also the name, address and telephone number of the supervising physician.” In addition, all prescriptions are required to have the name of both the supervising physician and the PA.

### **FEDERAL LAWS AND REGULATIONS GOVERNING PHYSICIAN ASSISTANTS**

This section provides a brief listing of federal law and regulations that apply to physician assistant practice as well as more detailed descriptions of the most important laws and regulations for this study. The federal government impacts PA practice through laws that have been enacted by Congress and regulations and/or policies set by federal agencies. It is important to note that federal law supercedes state law that is in conflict with the federal law’s provisions. The following areas have federal laws addressing PA practice:

- care of patients covered by Medicare
- care of patients covered by Medicaid
- care of hospitalized patients insofar as participation by hospitals in the Medicare program is contingent on a hospital following certain regulations

- care of residents in nursing homes
- in-office and hospital laboratories, under the Clinical Laboratories Improvement Act (CLIA)
- self-referral by health providers, under the Stark Acts
- prescription of controlled substances, under the Drug Enforcement Administration (DEA)
- confidential information about patients
- discrimination in hiring and firing
- facility access for disabled people

The discussion of policies concerning patients covered by Medicaid and Medicare mostly pertains to definitions and reimbursement and is of importance to the examination of third-party reimbursement as mandated by this study. One example is that when the Medicaid and Medicare programs were passed, there may not have been physician extenders practicing and the Social Security Act often refers to the term physician rather than being more inclusive with terms including other healthcare providers. The law has been amended over the years to include other healthcare providers. A more detailed discussion of these two programs concerning reimbursement is discussed in the following chapter.

Federal regulations in addressing the care provided in hospitals can impact PAs and PAs with prescriptive authority. In addressing care provided for Medicare patients, the Social Security Act stipulates that a physician must direct the care of hospitalized patients. However, physicians can delegate to other qualified healthcare personnel, which would likely include PAs. Similar provisions apply to patients covered by Medicare in nursing homes. In that setting, “the care of residents of a skilled nursing facility must be under the supervision of a physician.” Again, physicians can assign tasks to other qualified healthcare providers. Other federal provisions of interest include the Clinical Laboratories Improvement Act (CLIA), which provides federal oversight of any office or hospital laboratory, and the Stark Act, which prohibits self-referral by providers to another entity in which they have a financial interest.

An area of oversight that is of particular importance to this study is that of the requirements under the Drug Enforcement Administration (DEA). The DEA has the authority to license all healthcare providers that are prescribing controlled substances or what is referred to as scheduled drugs. Under these provisions, PAs are licensed as mid-level practitioners. Obtaining a DEA number is of great importance because the provider’s DEA number must be on the prescription to be valid. This stipulation helps to minimize the ability of someone to steal a prescription pad and still be able to obtain fraudulent prescriptions because the DEA number will not be on the pad.

### **III. Overview of Issues Related to Physician Assistants and Prescriptive Authority**

As stated previously, HB 2318 mandated the examination of a number of areas as they relate to physician assistant (PA) prescriptive authority. This chapter will examine patient care, patient satisfaction, provider relationships, physician practices, and third-party reimbursement as they relate to PAs in general and specifically to the expansion of PA prescriptive authority. However, the chapter will first provide an overview of the data that is and is not available, the data collected by the Board of Medicine and its relevance to this study, and an overview of PA prescriptive authority in other states. Lastly, this chapter will discuss some possible policy options.

#### **A MORE DEFINITIVE ASSESSMENT WOULD REQUIRE DATA THAT IS NOT AVAILABLE AT THIS TIME**

The Board of Medicine (BOM) collects some information about the physician assistants that they license. However, the collected data does not allow for comprehensive review of the impact expanded prescriptive authority has had on patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction with physician assistant treatment (the areas mandated by HB 2318). Some of the information that would be useful in examining these areas is not the type of data that the Board needs to license PAs. For example, a survey could collect information concerning the relationship between physicians and PAs and whether this relationship had been enhanced by additional PA prescriptive authority. Another example would be to collect information concerning patient satisfaction and whether that satisfaction had improved with additional PA prescriptive authority. (An example of data that could serve BOM in its licensing role is the collection of primary practice specialties of PAs.) Since BOM is funded through licensure fees, consideration should be given to funding directly any data collection required to evaluate prescriptive authority that would not directly contribute to BOM's mission of licensing PAs.

The following sections discuss the data that is collected concerning PA practice locations, complaints against PAs, and sanctions against PAs.

Additionally, one section will discuss the fact that BOM does not collect information regarding primary practice specialty which would enhance assessments of access to care in medically underserved areas. The Board should also review current data entry procedures to enhance the accuracy of the existing data.

### **Board of Medicine Collects Information on Practice Location**

The Board of Medicine collects data about the addresses of its licensees. BOM staff stated that the address collected is typically the business address of the PA. Figure 5 provides a general guide to the areas of the Commonwealth where PAs were practicing based on the most recent data collected by BOM. The regions of the state that would be considered more urban contained the most licensed PAs. These regions included Northern Virginia, Hampton Roads, and Central Virginia.

In addition, having information regarding the practice location of physician assistants allows a comparison to the primary care health professional shortage areas. A federal designation of a Health Professional Shortage Area (HPSA) and/or Medically Underserved Area (MUA) “is required for most of the key federal/state programs supporting the recruitment and retention of health care providers.” Most of the shortage areas are in rural parts of the state or in underserved urban areas. Examples of localities that have the primary care HPSA designation include Bland County, Grayson County, downtown Portsmouth, and Scott County.

JCHC staff compared the PA addresses that were provided to the BOM with the primary care HPSAs (as of March 23, 2004). However, it should be noted that there were multiple addresses for many PAs. Some of this duplication can be explained by PAs that may work in more than one practice location for the same provider(s), may work for more than one provider, may volunteer for another organization other than their primary place of work, etc. On the other hand, it is likely that some of the addresses are for previous places of employment. Within the database provided by BOM, there were a number of records in which no ending date of employment was provided, hence leaving a record that may be outdated in the system. JCHC staff eliminated duplicate addresses and practice locations to the extent possible. However, some outdated records may not have been identified and eliminated.

The JCHC staff analysis yielded 989 records with a Virginia address (including multiple records for some PAs). Only 950 records could be matched to a specific census tract for comparison to the primary care HPSAs.

**Figure 5  
Number of PAs per Virginia Region - 2004**

<b>Virginia Region</b>	<b>Number of Licensed PAs</b>
Northern Virginia	307
Hampton Roads	247
Central	152
Roanoke Area	91
Blue Ridge	85
Southside	68
Southwest	39
<b>Total</b>	<b>989*</b>

Source: *Data provided by the Board of Medicine on March 23, 2004, Department of Health Professions, 2004.*

Note: \*Count of 989 records based on removal of old and duplicate address records as well as the use of only Virginia records.

Ninety-four of the 950 records listed work addresses that were found to be in designated primary care HPSAs, or about 9.9 percent of records listing a Virginia address. Additionally, 72 records for PAs with prescriptive authority listed addresses that were found to be in primary care HPSAs, or about 7.6 percent of records listing a Virginia address.

**Information Concerning PA Practice Specialty Is Not Collected**

The Board of Medicine does not collect information regarding primary practice specialty for PAs. This information would be useful in comparing the locations in which PAs practice, the practice locations that are within a HPSA, and the practice specialties that are represented. At this time, because the annual survey by the American Academy of Physician Assistants (AAPA) collects information on primary practice specialty, some aggregate data is available. However, the aggregate data does not provide information about practice location. BOM may wish to consider collecting primary practice specialty information as part of the application for licensure process.

**Disciplinary Data Indicates that There Are Few Complaints and Sanctions Against PAs**

The Board of Medicine collects disciplinary data concerning complaints and sanctions imposed against licensed PAs. Additionally, as a subcategory, this information is available for licensed PAs with prescriptive authority. Figure 6

**Figure 6**  
**Complaints Resulting in an Investigation - July 1, 1999 – April 6, 2004**

<b>Case Category</b>	<b>Licensed PA</b>	<b>Licensed PA w/Presc. Authority</b>
Abandonment	-	-
Abuse-Mistreatment of Patient	1	1
Action by Another Board/Entity	2	1
Advertising-Misleading	1	-
Business Practices/Issues	-	-
Compliance	1	-
Confidentiality-Breach	-	-
Continued Competency Requirements	-	-
Criminal Activity/Conviction	1	1
Dishonored Check	1	1
Disclosure	1	-
Drug Related-Dispensing Drugs-Violating DCA	-	-
Drug Related-Failure to Maintain Security	-	-
Drug Related-Obtaining Drugs by Fraud	3	2
Drug Related-Other	1	1
Drug Related-Personal Use	1	1
Fraud	1	1
Inability to Safely Practice-Impairment	0	-
Inability to Safely Practice-Incapacitated	-	-
Inability to Safely Practice-Other	-	-
Licensure Eligibility	1	1
Misappropriation of Property	-	-
Neglect	1	1
Other	4	1
Prescription Blanks	23	18
Program or Facility Eligibility	1	1
Records/Inspections/Audits	-	-
Records Release	-	-
Reinstatement	1	-
Required Report not Filed	-	-
Relationship	-	-
Self-referral of Patients	-	-
Solicitation	1	1
Standard of Care-Consent	-	-
Standard of Care-Diagnosis Related	3	1
Standard of Care-Equipment/Product	-	-
Standard of Care-IV and Blood Products	-	-
Standard of Care-Malpractice Reports	-	-
Standard of Care-Prescription Related	12	6
Standard of Care-Other	2	1
Standard of Care-Surgery	-	-
Standard of Care-Treatment Related	15	9
Supervision	-	-
Unlicensed Activity	6	2
Unprofessional Conduct	3	-
<b>Total</b>	<b>87</b>	<b>51</b>

Source: *Physician Assistants Counts 04-06-2004, July 1, 1999 – April 6, 2004, Virginia Board of Medicine.*

summarizes the complaints for licensed PAs and licensed PAs with prescriptive authority for the time period of July 1, 1999 – April 6, 2004. This data indicates that the number of complaints against PAs is relatively low. The total of 87 complaints against PAs averages a little over two percent per year. The 51 complaints against PAs with prescriptive authority is about the same, averaging less than a little over two percent for the five-year period. The categories of complaints that are most related to prescriptive authority include: drug-related other, prescription blanks, and standard of care-prescription related.

Data related to sanctions imposed by BOM is summarized in Figure 7. The number of sanctions imposed against PAs, and as a subset, PAs with prescriptive authority is very low. As shown in Figure 7, the number of sanctions or actions imposed between July 1, 1999 – April 6, 2004 against PAs was 13, an average of less than one percent per year. The number of sanctions or actions imposed against PAs with prescriptive authority for that same time period was six, again an average of less than one percent per year.

These statistics indicate that there are very few disciplinary problems concerning licensed PAs and licensed PAs with prescriptive authority. Disciplinary data indirectly speaks to patient care and patient satisfaction which were mandated categories of examination for this study. BOM staff indicated that they have not observed significant increases in complaints or sanctions since the increased prescriptive authority started being phased-in. However, since the authority to prescribe Schedule IV drugs went into effect on January 1, 2003, there has been limited time to analyze any trends that might result from this increase. Moreover, the authority to prescribe Schedule III drugs will not occur until July 1, 2004.

**Figure 7**  
**Quantity and Type of Sanctions Imposed - July 1, 1999 – April 6, 2004**

<b>Sanction/Action Taken</b>	<b>Licensed PA</b>	<b>Licensed PA w/Presc. Authority</b>
Case Dismissed	1	-
Continued on Terms	-	-
License Surrendered	1	-
Mandatory Suspension	1	-
Monetary Penalty	-	-
No Action	6	3
Probation	2	2
Probation Terminated	1	1
Reinstatement Denied	-	-
Reinstatement Granted	-	-
Reprimand	-	-
Suspension	-	-
Suspension Stayed	-	-
Terms Imposed	-	-
Violation but No Sanction	1	-
<b>Total:</b>	<b>13</b>	<b>6</b>

Source: *Physician Assistants Counts 04-06-2004, July 1, 1999 – April 6, 2004*, Virginia Board of Medicine.

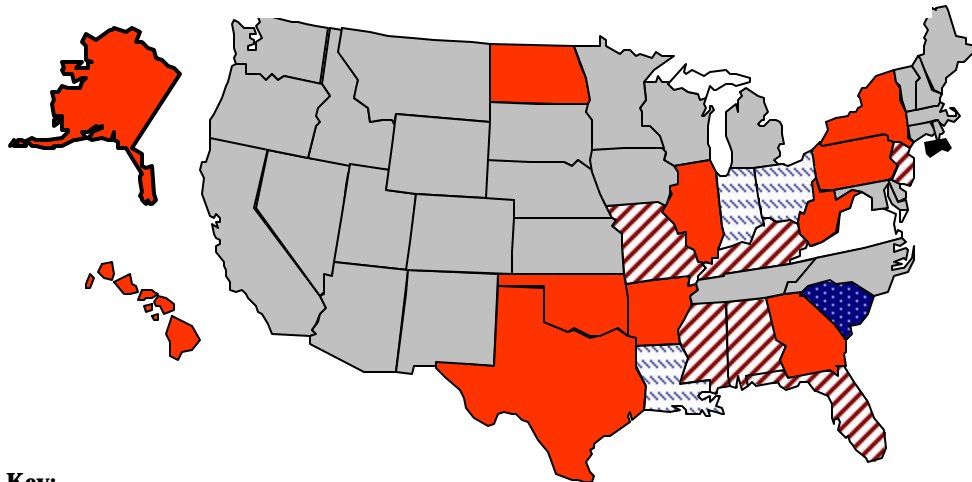
### **OVERVIEW OF POLICIES RELATED TO PHYSICIAN ASSISTANTS IN OTHER STATES**

In examining the impact that increased prescriptive authority of PAs has had in Virginia, it is important to examine the current status of PA prescriptive authority in other states. Figure 8 summarizes PA prescriptive authority by state. Twenty-eight states allow PAs to prescribe up to Schedule II controlled substances with physician involvement (although some states may have restrictions and/or formularies). Eleven states allow PAs to prescribe drugs through Schedule III controlled substances (although some states may have restrictions and/or formularies). A small number of states allow prescription of the lower schedules of controlled substances, a formulary of authorized drugs, or non-controlled substances. Three states allow no prescriptive authority for physician assistants; Ohio, Louisiana, and Indiana. Virginia is currently in a mid-range of the level of prescriptive authority allowed to PAs in comparison to other states but, will move up by authorizing as of July 1, 2004, PAs to prescribe Schedule III through VI controlled substances.










**Figure 8**

**Physician Assistant Prescriptive Authority by State**



**Key:**

-  Can prescribe through schedule II controlled substances
-  Can prescribe through schedule III controlled substances
-  Can prescribe through schedule IV controlled substances
-  Can prescribe through schedule V controlled substances
-  Can prescribe through schedule VI controlled substances
-  Formulary or non-controlled substances
-  No prescriptive authority.

Note: It should be noted that some states that allow higher schedules to be prescribed, have restrictions on those schedules and/or a formulary.

Source: *Where Physicians Are Authorized to Prescribe*, The American Academy of Physicians, website, 2-16-04.

As far as regulatory requirements for licensure, PAs in 45 states must graduate from a physician assistant program and pass the National Commission for Certification of Physician Assistants (NCCPA) exam. (Virginia is included in this category.) In Minnesota, North Dakota, and Ohio, the applicant must pass the NCCPA exam but does not have to be a graduate of a PA educational program. In Maine, applicants must either be a graduate of a PA educational program and/or pass the NCCPA exam. Missouri essentially requires both the education and exam requirements, but grandfathers in those who were employed as PAs prior to 1986.

The level of supervision required for PAs varies widely between states. Although, some states require direct, on-site supervision, most do not. Other states allow for supervisory contact via some type of telecommunication. There are also stipulations in some states for chart review or cosigning within a variety of time-periods. Virginia requires continuous supervision but the physician does not have to be physically present at all times.

### **STUDIES HAVE SHOWN THAT QUALITY CARE IS PROVIDED BY PAS**

The legislation expanding prescriptive authority of PAs (HB 2318, 2001) required an analysis of the impact of increased prescriptive authority in patient care and the quality of patient care. An examination of a large number of studies was completed by the Office of Technology and Assessment (OTA) in the late 1980s for the purpose of evaluating the contributions of NPs, certified nurse midwives (CNMs), and physician assistants in meeting health-care needs. The OTA reported: “Numerous independent studies have concluded that the quality of medical care provided by PAs is equivalent to that of physicians when PAs are practicing within the scope of their education and training.”

The OTA in its review of numerous studies concluded that the “weight of the evidence indicates that, within their areas of competence, NPs, PAs, and CNMs provide care whose quality is equivalent to that of care provided by physicians... The evidence indicates that PAs also perform better than many physicians in supportive-care and health-promotion activities.” The OTA study found that PAs generally performed well when compared to physicians with regards to counseling and educating patients and also found that patients often resumed their normal level of functioning more quickly.

As part of this study, JCHC staff contacted PA programs, associations, and other sources to inquire about Virginia-specific data regarding PAs and prescriptive authority. That inquiry revealed that Virginia-specific data on PAs is lacking. It is important to consider that expanded prescriptive authority is relatively new and this contributes to the lack of available data when trying to examine this issue specifically. Although, Virginia-specific data is unavailable, some anecdotal information was collected that supports the premise that increased prescriptive authority for PAs has had a positive impact on patient care. The following are quotes received from PAs on this topic:

It enables the patient to be better served, not having to wait on a MD to sign or to see one for things such as anxiety, coughs that require codeine cough medicine. It gives the patient more choices for care and who they are going to see.

Patient care has been improved through the use of class drugs. Pain has been better managed, in a more efficient time period.

For the most part, patients at our practice would choose to see me at times instead of the physician because they knew I would take the time to listen and understand their concerns and do a thorough work-up as well as communicate those concerns to the supervising physician. I was the person who followed up with them after surgery, took care of little concerns that needed to be addressed, and spent the necessary time listening to them.

I have had a much easier time arranging hospice since they use my DEA number to order the 'emergency' breakthrough meds that they leave at my patients' houses. I have had a need for duragesic patches for dying patients and they did not need to wait for one of my docs to be found and a family member to be sent to where that doc was. They could die comfortably and easily in their own houses.

Lastly, as mentioned previously, the relatively low number of complaints and sanctions against PAs and PAs with prescriptive authority also indirectly indicates that quality care is being provided by PAs in Virginia.

### **STUDIES EXAMINING PAS HAVE SHOWN THAT PATIENTS ARE SATISFIED WITH THEIR CARE**

The previous section examined the quality of care or patient care which is closely intertwined with patient satisfaction. The previously mentioned Office of Technology Assessment (OTA) review examined a number of studies concerning the quality of care that patients received. (Patient satisfaction was a secondary factor on which data was collected in a number of these studies). The OTA review found that, "Patients are generally satisfied with the quality of care provided by NPs, PAs, and CNMs, particularly with the interpersonal aspects of care." The studies that directly addressed patient satisfaction, "indicate that patients generally are as highly satisfied with the care they receive from PAs...." The available data generally indicates that patients are satisfied with the care that they receive from PAs. The low incidence of complaints and sanctions against PAs in Virginia also indirectly indicates patient satisfaction.

It is likely that patient satisfaction with the care provided by PAs has increased for some patients in accordance with increased PA prescriptive authority. JCHC staff contacts for this study suggested that increased PA prescriptive authority decreased wait times for some patients. Other examples of situations that would allow for action by a PA that would lead to increased satisfaction include the quotes that follow.

Patients [are] very satisfied in the fact that they don't have to wait on MD which usually is a much longer wait to see than a PA. Many of our patients actually feel more comfortable asking and talking to the PA. They feel we are more on "their level" and being able to confidentially talk and us not having to go "wait on the physician to sign a

prescription" let's the patient get more efficient service. That is one of the more important things in our particular practice.

Patients are happier because we have more room to move in our prescribing abilities. Also, we are now allowed to use the education we sacrificed so dearly for.

Again, the BOM data on complaints and sanctions of PAs with prescriptive authority are relatively low, indirectly indicating patient satisfaction with PA prescriptive authority.

## **RESEARCH ON PROVIDER RELATIONSHIPS IS AMBIGUOUS**

The OTA review of studies pertaining to PAs examined the issue of provider relationships. Concerning physicians who employ NPs, PAs, and certified nurse mid-wives the OTA reported:

Although most physicians who employ these practitioners are satisfied with their performance, physicians' willingness to delegate medical tasks is limited. Many physicians are more comfortable delegating the routine tasks related to primary care, such as taking histories, than the more technical procedures, such as physical examinations.

Also, the OTA assessment found "that many physicians accept PAs and are satisfied with their work...." The examination of multiple studies by the OTA also found the following:

Physicians' confidence in PAs extends beyond routine care. One recent study found that although physicians generally delegate routine, uncomplicated cases to PAs, physicians also permit PAs to treat walk-in patients with urgent problems if the physicians cannot treat those patients and honor previously scheduled appointments (57). Perry and Breitner (182) found that supervising physicians rate PAs higher than NPs on tasks involving educating, counseling, or instructing patients.

The high level of physicians' satisfaction with PAs may help account for their continued high employment rate. Employment rates provide the most consequential expression of physicians' acceptance, and nearly 86 percent of the Nation's PAs were employed as PAs in 1981 (45). By 1984, the employment rate had increased slightly to approximately 88 percent; only 8.4 percent had not been employed as PAs for more than a year (219).

These findings suggest that PA relationships with physicians were generally positive with some limitations. However, the OTA study was from the late 1980s. Since that time, physicians have continued to employ and work with PAs. The following quote is one example from a health center of anecdotal evidence that suggests that current provider relationships seem to be satisfactory, at least on an individual basis and have benefited from increased prescriptive authority.

I talked with the providers [in my health center] about the expanded prescriptive authority for PAs, and they had very favorable comments. We have a physician and a PA on staff, and they contend that this authority impacts continuity of care in a positive way. The PA can manage her patient's care including these Schedule medications, without having to turn the case over to the physician. It saves time for both providers, and the patient is more satisfied because care is not disrupted by switching providers midstream.

On the other hand, attempts by healthcare professionals to expand their scope of authority more independently is often met with resistance from physician groups, which can make relationships between physicians and the other providers strained. It seems that the relationship between physicians and PAs is relatively positive. PA programs are modeled on supervision being received from physicians. Therefore, it seems that relationships with PAs and physicians are likely to be good when there is a direct working relationship between the providers. However, physicians as a group and PAs as a group might be at odds over some larger policy issues at times, especially on questions of scope of practice issues (including prescriptive authority) which give non-physicians more independence.

### **The Impact of Increased PA Prescriptive Authority on Provider Relationships Seems to be Positive**

In examining the impact that increased PA prescriptive authority has had on provider relationships, both nationally and in Virginia, JCHC staff contacted relevant professional associations and researched statements by organizations. For example, the American Medical Association (AMA) generally opposes expansion of non-physician scope of practice issues, including the expansion of prescriptive authority to non-physician providers. On the other hand, relationships between PAs and individual physicians with which they work appear to generally be positive. An example of this relationship follows in a quote from a physician assistant:

During my practice, I have always had wonderful relationships with my supervising physicians. A good practice relationship is based on trust. Trust is built on expectations being met, excellence in skill level, and establishment of solid and reliable practice experience together. As a Physician Assistant, it has always been my good practice to know my own limitations, and discuss cases with my supervising physician which fell outside the normal prescriptive or diagnostic routine. Practice is Partnership. Having the ability to prescribe allows my supervising physician to use me remotely to care and prescribe for his patients without having to reschedule them, send them to another facility, or turn them down for care if he is not on the premises. It is part of the basis for the autonomy he expects from me as a PA.

## **SOME PHYSICIAN PRACTICES WERE IMPACTED BY INCREASED PA PRESCRIPTIVE AUTHORITY**

According to Virginia Health Information (VHI), there are more than 31,000 licensed physicians in Virginia. The number of licensed PAs in Virginia is 957 and the number of PAs with prescriptive authority is 697. Therefore, the impact of increased prescriptive authority for less than 700 PAs would not seem to be particularly significant for the majority of physicians. However, physicians in practice were impacted in their day-to-day operations if they employed PAs when the PA prescriptive authority increased. Individuals contacted during this study suggested that the increased PA prescriptive authority was beneficial to physicians and PAs. Some individuals commenting on this study felt that the increase in prescriptive authority reduced some burdens. For example, if the physician were at another satellite practice office, the PA could be allowed to write prescriptions so the doctor would not have to write the prescriptions at a later time. This not only increases the efficiency of the practice but it improves patient satisfaction with being able to receive care and/or the prescriptions more quickly. The following are comments received by PAs relating to physician practices.

The physician does not have to see every patient that a scheduled drug is written for at that time. It enables them to concentrate on the more complicated issues with patients thus allowing better service to the patient.

Practice is more efficient and patients are satisfied with competent help.

## **OVERVIEW OF PHYSICIAN ASSISTANT REIMBURSEMENT CATEGORIES**

This section will examine the way different payers reimburse PAs in general and where possible the section will specifically address reimbursement in Virginia. For instance, there exists some difference in the way Medicare, Medicaid, indemnity insurance companies, managed care organizations, and businesses that contract for certain services choose to reimburse PAs. Additionally, since Medicaid is a federal-state partnership, there can be quite a variation from state-to-state as to how reimbursement is handled.

### **Payment of PA Services Under the Medicare Program.**

The Medicare program is a federal program that mainly provides coverage to Americans age 65 and older, as well as several other narrowly defined categories of recipients. The Rural Health Clinic Services Act of 1977 was the first time coverage of PA services was covered under Medicare. This legislation covered PA services that previously would have only been provided

by a physician. Coverage was incrementally expanded over the years that followed.

The Balanced Budget Act (BBA) of 1997 significantly changed the way PAs are reimbursed under Medicare. Medicare has both a fee-for-service program and a managed care program. The BBA expanded previous Medicare eligibility to allow PAs to receive direct Medicare reimbursement under the fee-for-service program at the lesser of 85 percent of the Medicare-approved physician rate under the fee schedule or 80 percent of the actual charge. To receive direct reimbursement PAs must apply to be a Medicare provider. Although this change has allowed for direct Medicare reimbursement to PAs, it was anecdotally reported that some PAs might not bill directly for their services. This is most likely a result of the provision that allows a PA to bill as “incident to” a physician. “Incident to” billing allows the service to still be billed under the physician’s name and at the physician rate under the fee schedule. These services include outpatient services that are provided in physician offices and/or clinics. Certain stipulations must be met to bill under the “incident to” provision. To bill directly for services provided for Medicare patients with managed care coverage, the PA must apply to the managed care organization for admission to the organization’s provider panel. The managed care organization negotiates its rates with providers or groups of providers.

### **Payment of PA Services Under the Medicaid Program**

The Medicaid program provides medical and medically-related services for the poor through dual financing from state and federal governments. Because Medicaid programs are administered at the state-level, there is the potential for a great deal of variation in PA reimbursement. According to the AAPA, “Presently, 50 states cover medical services provided by PAs under their Medicaid programs. The rate of reimbursement, which is paid to the employing practice and not directly to the PA, is either the same as or slightly lower than that paid to physicians.” According to DMAS, there are three options for states concerning reimbursement for PAs:

- (1) allow them to directly enroll and bill for services rendered
- (2) require [them] to work under physicians and bill as part of the physician benefit (Virginia)
- (3) choose not to permit coverage of PA services at all.

Therefore, some states do not recognize PAs as an independent provider type. However, under fee-for-service programs that allow direct reimbursement, PAs have to apply to a state Medicaid program to receive a Medicaid provider number. Depending on state law, the PA will receive up to 100 percent of the

fee-for-service rate paid to a physician. Under the Virginia Medicaid program, physician assistants do not receive direct reimbursement.

If a state Medicaid program has a managed care program, the procedure to receive reimbursement is different. The following includes an explanation from the AAPA regarding Medicaid managed care providers:

Medicaid managed care arrangements typically involve a primary care provider who acts as gatekeeper and coordinates the delivery of care. State Medicaid programs include different professionals in their lists of primary care providers. Family physicians, general practitioners, pediatricians and internists are routinely included. Some states also define physician assistants, obstetricians/gynecologists, and nurse practitioners as primary care providers. Some jurisdictions specify that PAs and NPs may serve in association with physicians, that physicians may be supported by PAs and advanced practice nurses, or that the managed care organization may determine the composition of the primary care network.

Therefore, to bill directly for services, the PA has to apply to the managed care organization to request admittance to the provider panel. Again, the managed care organization negotiates its rates with providers or groups of providers. In Virginia, PAs cannot be primary care providers (PCPs) under the Medicaid managed care programs.

### **Payment of PAs by Indemnity Insurance Companies**

Indemnity insurance companies are companies that reimburse for the cost of medical care of individuals insured by the company but do not provide the medical care. These companies usually pay providers on a per-visit, per-procedure basis based on what is typically referred to as a “usual and customary” fee schedule. Receiving payment from an indemnity insurance company requires a PA to submit the appropriate billing form to the company (for the companies directly reimbursing PAs). If the company does not directly reimburse PAs, the services are usually billed under the physician’s name and provider number, according to the specific policies of the insurance company. Most companies pay claims that have been filed under the physician’s name and provider number.

### **Payment of PAs by Managed Care Organizations**

Managed care programs (apart from Medicare and Medicaid) typically are organizations that provide both health care services and payment for the services. To receive payments for MCO patients, the PA must apply to be on the provider panel and, as noted previously, the MCO then negotiates its payment



rates with the provider, group of providers, practice, or other group. Practices of MCOs vary hence, not all MCOs allow PAs to be PCPs.

**Payments of PAs by Businesses that Contract for Direct Services.**

Examples of this type of direct contract for services include colleges and universities as well as businesses for such items as occupational health services. A PA may choose to contract to provide these services. Negotiating rates and the terms of the services provided would be specific to the individual situation and involves a great deal of variability.



## **IV. Policy Options**

The following Policy Options were offered for consideration by the Joint Commission on Health Care. On November 15, 2004, the Commission voted in support of Option I, to take no action.

**Option I:            Take no Action.**

**Option II:            By letter from the Joint Commission on Health Care or by joint resolution request that the Board of Medicine (1) collect data regarding the primary specialty of licensed physician assistants and (2) review the accuracy of existing data regarding practice locations. The letter or joint resolution should require the Board of Medicine to report to the Joint Commission on its progress by October 1, 2005.**

**Option III:            Introduce a budget amendment to fund a survey of physicians and physician assistants regarding the impact of prescriptive authority for physician assistants on patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction. The survey results should be reported to the Governor and the General Assembly no later than the first day of the 2006 Regular Session of the General Assembly.**

No public comments were received in connection with this study.



## **APPENDIX A**



# VIRGINIA ACTS OF ASSEMBLY -- 2001 SESSION

## CHAPTER 465

*An Act to amend and reenact §§ 9-6.14:4.1, 54.1-2952.1, 54.1-3301, 54.1-3303, and 54.1-3422 of the Code of Virginia, relating to prescriptive authority of physician assistants.*

[H 2318]

Approved March 20, 2001

**Be it enacted by the General Assembly of Virginia:**

**1. That §§ 9-6.14:4.1, 54.1-2952.1, 54.1-3301, 54.1-3303, and 54.1-3422 of the Code of Virginia are amended and reenacted as follows:**

§ 9-6.14:4.1. Exemptions and exclusions.

A. Although required to comply with § 9-6.18 of the Virginia Register Act (§ 9-6.15 et seq.), the following agencies are exempted from the provisions of this chapter, except to the extent that they are specifically made subject to §§ 9-6.14:14.1, 9-6.14:21 and 9-6.14:22:

1. The General Assembly.
2. Courts, any agency of the Supreme Court, and any agency which by the Constitution is expressly granted any of the powers of a court of record.
3. The Department of Game and Inland Fisheries in promulgating regulations regarding the management of wildlife and for all case decisions rendered pursuant to any provisions of Chapters 2 (§ 29.1-200 et seq.), 3 (§ 29.1-300 et seq.), 4 (§ 29.1-400 et seq.), 5 (§ 29.1-500 et seq.), and 7 (§ 29.1-700 et seq.) of Title 29.1.
4. The Virginia Housing Development Authority.
5. Municipal corporations, counties, and all local, regional or multijurisdictional authorities created under this Code, including those with federal authorities.
6. Educational institutions operated by the Commonwealth, provided that, with respect to § 9-6.14:22, such educational institutions shall be exempt from the publication requirements only with respect to regulations which pertain to (i) their academic affairs; (ii) the selection, tenure, promotion and disciplining of faculty and employees; (iii) the selection of students; and (iv) rules of conduct and disciplining of students.
7. The Milk Commission in promulgating regulations regarding (i) producers' licenses and bases, (ii) classification and allocation of milk, computation of sales and shrinkage, and (iii) class prices for producers' milk, time and method of payment, butterfat testing and differential.
8. The Virginia Resources Authority.
9. Agencies expressly exempted by any other provision of this Code.
10. The Virginia Voluntary Formulary Board in formulating recommendations regarding amendments to the Formulary pursuant to § 32.1-81.
11. [Repealed.]
12. The Department of General Services in promulgating standards for the inspection of buildings for asbestos pursuant to § 2.1-526.14.
- 13., 14. [Repealed.]
15. The State Council of Higher Education for Virginia, in developing, issuing, and revising guidelines pursuant to § 23-9.6:2.
16. The Commissioner of Agriculture and Consumer Services in adopting regulations pursuant to subsection B of § 3.1-726.
17. The Commissioner of Agriculture and Consumer Services and the Board of Agriculture and Consumer Services in promulgating regulations pursuant to subsections B and C of § 3.1-106.4, subsection B of § 3.1-126.12:1, § 3.1-271.1, § 3.1-398, subsections B and C of § 3.1-828.4, and subsection A of § 3.1-884.21:1.
18. The Board of Optometry when specifying therapeutic pharmaceutical agents, treatment guidelines, and diseases and abnormal conditions of the human eye and its adnexa for TPA-certification of optometrists pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32 of Title 54.1.
19. ~~The Board of Medicine, in consultation with the Board of Pharmacy, when promulgating~~

~~amendments to the Physician Assistant Formulary established pursuant to § 54.1-2952.1.~~

20. The Virginia War Memorial Foundation.

24. 20. The Virginia Medicaid Prior Authorization Advisory Committee in making recommendations to the Board of Medical Assistance Services regarding prior authorization for prescription drug coverage pursuant to Article 4 (§ 32.1-331.12 et seq.) of Chapter 10 of Title 32.1.

22. 21. The State Board of Education, in developing, issuing, and revising guidelines pursuant to § 22.1-280.3.

23. 22. The Virginia Racing Commission, when acting by and through its duly appointed stewards or in matters related to any specific race meeting.

24. 23. The Virginia Small Business Financing Authority.

25. 24. The Virginia Economic Development Partnership Authority.

26. 25. The Board of Agriculture and Consumer Services in adopting, amending or repealing regulations pursuant to subsection A (ii) of § 59.1-156.

27. 26. The Insurance Continuing Education Board pursuant to § 38.2-1867.

28. 27. The Board of Health in promulgating the list of diseases that shall be reported to the Department of Health pursuant to § 32.1-35.

29. 28. The Virginia Racing Commission in promulgating technical rules regulating actual live horse racing at race meetings licensed by the Commission.

B. Agency action relating to the following subjects is exempted from the provisions of this chapter:

1. Money or damage claims against the Commonwealth or agencies thereof.

2. The award or denial of state contracts, as well as decisions regarding compliance therewith.

3. The location, design, specifications or construction of public buildings or other facilities.

4. Grants of state or federal funds or property.

5. The chartering of corporations.

6. Customary military, naval or police functions.

7. The selection, tenure, dismissal, direction or control of any officer or employee of an agency of the Commonwealth.

8. The conduct of elections or eligibility to vote.

9. Inmates of prisons or other such facilities or parolees therefrom.

10. The custody of persons in, or sought to be placed in, mental, penal or other state institutions as well as the treatment, supervision, or discharge of such persons.

11. Traffic signs, markers or control devices.

12. Instructions for application or renewal of a license, certificate, or registration required by law.

13. Content of, or rules for the conduct of, any examination required by law.

14. The administration of a pool or pools authorized by Article 7.1 (§ 2.1-234.9:1 et seq.) of Chapter 14 of Title 2.1.

15. Any rules for the conduct of specific lottery games, so long as such rules are not inconsistent with duly adopted regulations of the State Lottery Board, and provided that such regulations are published and posted.

16. Orders condemning or closing any shellfish, finfish, or crustacea growing area and the shellfish, finfish or crustacea located thereon pursuant to Article 2 (§ 28.2-803 et seq.) of Chapter 8 of Title 28.2.

17. Any operating procedures for review of child deaths developed by the State Child Fatality Review Team pursuant to § 32.1-283.1.

18. The regulations for the implementation of the Health Practitioners' Intervention Program and the activities of the Intervention Program Committee pursuant to Chapter 25.1 (§ 54.1-2515 et seq.) of Title 54.1.

19. The process of reviewing and ranking grant applications submitted to the Commonwealth Neurotrauma Initiative Advisory Board pursuant to Article 12 (§ 32.1-73.1 et seq.) of Chapter 2 of Title 32.1.

20. Loans from the Small Business Environmental Compliance Assistance Fund pursuant to Article 4 (§ 10.1-1197.1 et seq.) of Chapter 11.1 of Title 10.1.

21. The Virginia Breeders Fund created pursuant to § 59.1-372.



22. The types of pari-mutuel wagering pools available for live or simulcast horse racing.

23. The administration of medication or other substances foreign to the natural horse.

C. The following agency actions otherwise subject to this chapter and § 9-6.18 of the Virginia Register Act are excluded from the operation of Article 2 (§ 9-6.14:7.1 et seq.) of this chapter:

1. Agency orders or regulations fixing rates or prices.

2. Regulations which establish or prescribe agency organization, internal practice or procedures, including delegations of authority.

3. Regulations which consist only of changes in style or form or corrections of technical errors. Each promulgating agency shall review all references to sections of the Code of Virginia within their regulations each time a new supplement or replacement volume to the Code of Virginia is published to ensure the accuracy of each section or section subdivision identification listed.

4. Regulations which:

(a) Are necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved;

(b) Are required by order of any state or federal court of competent jurisdiction where no agency discretion is involved; or

(c) Are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation, and the Registrar has so determined in writing; notice of the proposed adoption of these regulations and the Registrar's above determination shall be published in the Virginia Register not less than thirty days prior to the effective date thereof.

5. Regulations which an agency finds are necessitated by an emergency situation. For the purposes of this subdivision, "emergency situation" means (i) a situation involving an imminent threat to public health or safety or (ii) a situation in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation shall be effective in 280 days or less from enactment of the law or the appropriation act or the effective date of the federal regulation, and the regulation is not exempt under the provisions of subdivision C 4 of this section. In such cases, the agency shall state in writing the nature of the emergency and of the necessity for such action and may adopt such regulations. Pursuant to § 9-6.14:9, such regulations shall become effective upon approval by the Governor and filing with the Registrar of Regulations. Such regulations shall be limited to no more than twelve months in duration. During the twelve-month period, an agency may issue additional emergency regulations as needed addressing the subject matter of the initial emergency regulation, but any such additional emergency regulations shall not be effective beyond the twelve-month period from the effective date of the initial emergency regulation. If the agency wishes to continue regulating the subject matter governed by the emergency regulation beyond the twelve-month limitation, a regulation to replace the emergency regulation shall be promulgated in accordance with Article 2 (§ 9-6.14:7.1 et seq.) of this chapter. The Notice of Intended Regulatory Action to promulgate a replacement regulation shall be filed with the Registrar within sixty days of the effective date of the emergency regulation and published as soon as practicable, and the proposed replacement regulation shall be filed with the Registrar within 180 days after the effective date of the emergency regulation and published as soon as practicable.

6. [Repealed.]

7. Preliminary program permit fees of the Department of Environmental Quality assessed pursuant to subsection C of § 10.1-1322.2.

8. Regulations of the Pesticide Control Board adopted pursuant to subsection B of § 3.1-249.51 or clause (v) or (vi) of subsection C of § 3.1-249.53 after having been considered at two or more Board meetings and one public hearing.

9. Regulations of the regulatory boards served by (i) the Department of Labor and Industry pursuant to Title 40.1 and (ii) the Department of Professional and Occupational Regulation or the Department of Health Professions pursuant to Title 54.1 which are limited to reducing fees charged to regulants and applicants.

10. The development and issuance of procedural policy relating to risk-based mine inspections by the Department of Mines, Minerals and Energy authorized pursuant to §§ 45.1-161.82 and 45.1-161.292:55.

11. General permits issued by the State Air Pollution Control Board pursuant to Chapter 13 (§ 10.1-1300 et seq.) of Title 10.1 if the Board: (i) provides a Notice of Intended Regulatory Action in conformance with the provisions of subsection B of § 9-6.14:7.1, (ii) following the passage of thirty days from the publication of the Notice of Intended Regulatory Action forms a technical advisory committee composed of relevant stakeholders, including potentially affected citizens groups, to assist in the development of the general permit, (iii) provides notice and receives oral and written comment as provided in subsection F of § 9-6.14:7.1, and (iv) conducts at least one public hearing on the proposed general permit.

12. General permits issued by the State Water Control Board pursuant to the State Water Control Law (§ 62.1-44.2 et seq.), Chapter 24 (§ 62.1-242 et seq.) of Title 62.1 and Chapter 25 (§ 62.1-254 et seq.) of Title 62.1 if the Board: (i) provides a Notice of Intended Regulatory Action in conformance with the provisions of subsection B of § 9-6.14:7.1, (ii) following the passage of thirty days from the publication of the Notice of Intended Regulatory Action forms a technical advisory committee composed of relevant stakeholders, including potentially affected citizens groups, to assist in the development of the general permit, (iii) provides notice and receives oral and written comment as provided in subsection F of § 9-6.14:7.1, and (iv) conducts at least one public hearing on the proposed general permit.

13. The development and issuance by the Board of Education of guidelines on constitutional rights and restrictions relating to the recitation of the pledge of allegiance to the American flag in public schools pursuant to § 22.1-202.

14. Regulations of the Board of the Virginia College Savings Plan promulgated pursuant to § 23-38.77.

15. The development and issuance of general wetlands permits by the Marine Resources Commission pursuant to subsection B of § 28.2-1307 if the Commission: (i) provides a Notice of Intended Regulatory Action in conformance with the provisions of subsection B of § 9-6.14:7.1, (ii) following the passage of thirty days from publication of the Notice of Intended Regulatory Action forms a technical advisory committee composed of relevant stakeholders, including potentially affected citizens groups, to assist in the development of the general permit, (iii) provides notice and receives oral and written comment as provided in subsection F of § 9-6.14:7.1, and (iv) conducts at least one public hearing on the proposed general permit.

Whenever regulations are adopted under this subsection, the agency shall state as part thereof that it will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision. The effective date of regulations adopted under this subsection shall be in accordance with the provisions of § 9-6.14:9.3, except in the case of emergency regulations, which shall become effective as provided in subsection B of § 9-6.14:9.

D. The following agency actions otherwise subject to this chapter are excluded from the operation of Article 3 (§ 9-6.14:11 et seq.) of this chapter:

1. The assessment of taxes or penalties and other rulings in individual cases in connection with the administration of the tax laws.

2. The award or denial of claims for workers' compensation.

3. The grant or denial of public assistance.

4. Temporary injunctive or summary orders authorized by law.

5. The determination of claims for unemployment compensation or special unemployment.

6. The suspension of any license, certificate, registration or authority granted any person by the Department of Health Professions or the Department of Professional and Occupational Regulation for the dishonor, by a bank or financial institution named, of any check, money draft or similar instrument used in payment of a fee required by statute or regulation.

E. Appeals from decisions of the Governor's Employment and Training Department otherwise subject to this chapter are excluded from the operation of Article 4 (§ 9-6.14:15 et seq.) of this chapter.

F. The Marine Resources Commission, otherwise subject to this chapter and § 9-6.18 of the Virginia Register Act, is excluded from the operation of subdivision C 5 of this section and of Article 2 (§ 9-6.14:7.1 et seq.) of this chapter.

G. A regulation for which an exemption is claimed under this section and ~~which~~ *that* is placed

before a board or commission for consideration shall be provided at least two days in advance of the board or commission meeting to members of the public that request a copy of that regulation. A copy of that regulation shall be made available to the public attending such meeting.

H. The Joint Legislative Audit and Review Commission shall conduct a review periodically of exemptions and exclusions authorized by this section. The purpose of this review shall be to assess whether there are any exemptions or exclusions which should be discontinued or modified.

I. Minor changes to regulations being published in the Virginia Administrative Code under the Virginia Register Act, Chapter 1.2 (§ 9-6.15 et seq.) of this title, made by the Virginia Code Commission pursuant to § 9-77.10:1 shall be exempt from the provisions of this chapter.

§ 54.1-2952.1. Prescription of certain controlled substances and devices by licensed physician assistant.

A. *In accordance with the provisions of this section and pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.) of this title, a licensed physician assistant shall have the authority to prescribe Schedule VI controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.) of this title pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.) of this title as follows: (i) Schedules V and VI controlled substances on and after July 1, 2001 and (ii) Schedules IV through VI controlled substances on and after January 1, 2003.*

*A licensed physician assistant shall have such prescriptive authority upon the provision to the Board of Medicine of such evidence as it may require that the assistant has entered into and is, at the time of writing a prescription, a party to a written agreement with a licensed physician or podiatrist which provides for the direction and supervision by such licensee of the prescriptive practices of the assistant. Such written agreements shall include the controlled substances the physician assistant is or is not authorized to prescribe and may restrict such prescriptive authority as deemed appropriate by the physician or podiatrist providing direction and supervision.*

B. It shall be unlawful for the assistant to prescribe controlled substances or devices pursuant to this section unless such prescription is authorized by the written agreement between the licensee and the assistant.

C. The Board of Medicine, in consultation with the Board of Pharmacy, shall promulgate such regulations governing the prescriptive authority of *physician* assistants as are deemed reasonable and necessary to ensure an appropriate standard of care for patients.

The regulations promulgated pursuant to this section shall include, at a minimum, (i) a ~~formulary of the specific Schedule VI drugs and devices that the assistant is eligible to prescribe pursuant to this section to the extent, and in the manner, authorized in a written protocol between the assistant and the supervising licensee such requirements as may be necessary to ensure continued physician assistant competency that may include continuing education, testing, and/or any other requirement, and shall address the need to promote ethical practice, an appropriate standard of care, patient safety, the use of new pharmaceuticals, and appropriate communication with patients;~~ (ii) requirements for periodic site visits by supervising licensees who supervise and direct assistants who provide services at a location other than where the licensee regularly practices; and (iii) a requirement that the assistant disclose to his patients the name, address and telephone number of the supervising licensee and that he is a physician assistant. A separate office for the assistant shall not be established.

~~In order to maintain a current and appropriate list of specific Schedule VI drugs and devices, the Board of Medicine, in consultation with the Board of Pharmacy, may, from time to time, amend the formulary required by this subsection and, as provided in § 9-6.14:4.1, shall be exempted from the Administrative Process Act (§ 9-6.14:1 et seq.) when so doing. The Boards shall, however, jointly conduct public hearings prior to making such amendments to the formulary. Thirty days prior to conducting such hearing, the Boards shall give written notice by mail of the date, time, and place of the hearings to all currently licensed assistants and any other persons requesting to be notified of the hearings and publish notice of their intention to amend the formulary in the Virginia Register of Regulations. Interested parties shall be given reasonable opportunity to be heard and present information prior to final adoption of any amendments. Proposed and final amendments of the list shall also be published, pursuant to § 9-6.14:22, in the Virginia Register of Regulations. Final amendments to the formulary shall become effective upon filing with the Registrar of Regulations.~~

D. This section shall not prohibit a licensed physician assistant from administering Schedule VI

controlled substances in compliance with the definition of "administer" in § 54.1-3401 or from receiving and dispensing manufacturers' professional samples of ~~Schedule VI~~ controlled substances in compliance with the provisions of this section.

§ 54.1-3301. Exceptions.

This chapter shall not be construed to:

1. Interfere with any legally qualified practitioner of dentistry, or veterinary medicine or any physician acting on behalf of the Virginia Department of Health or local health departments, in the compounding of his prescriptions or the purchase and possession of drugs as he may require;

2. Prevent any legally qualified practitioner of dentistry, or veterinary medicine or any physician acting on behalf of the Virginia Department of Health or local health departments, from administering or supplying to his patients the medicines that he deems proper under the conditions of § 54.1-3303;

3. Prohibit the sale by merchants and retail dealers of proprietary medicines as defined in Chapter 34 (§ 54.1-3400 et seq.) of this title;

4. Prevent the operation of automated drug dispensing systems in hospitals pursuant to Chapter 34 (§ 54.1-3400 et seq.) of this title;

5. Prohibit the employment of ancillary personnel to assist a pharmacist as provided in the regulations of the Board;

6. Interfere with any legally qualified practitioner of medicine, osteopathy, or podiatry from purchasing, possessing or administering controlled substances to his own patients or providing controlled substances to his own patients in a bona fide medical emergency or providing manufacturers' professional samples to his own patients;

7. Interfere with any legally qualified practitioner of optometry, certified or licensed to use diagnostic pharmaceutical agents, from purchasing, possessing or administering those controlled substances as specified in § 54.1-3221 or interfere with any legally qualified practitioner of optometry certified to prescribe therapeutic pharmaceutical agents from purchasing, possessing, or administering to his own patients those controlled substances as specified in § 54.1-3222 and the TPA formulary or providing manufacturers' samples of these drugs to his own patients; ~~or~~

8. Interfere with any physician assistant with prescriptive authority receiving and dispensing to his own patients manufacturers' professional samples of ~~those~~ ~~Schedule VI~~ controlled substances and devices ~~which~~ *that* he is authorized, *in compliance with the provisions of § 54.1-2952.1*, to prescribe *according to his practice setting and a written agreement with a physician or podiatrist; or*

9. Interfere with any licensed nurse practitioner with prescriptive authority receiving and dispensing to his own patients manufacturers' professional samples of controlled substances and devices that he is authorized, in compliance with the provisions of § 54.1-2957.01, to prescribe according to his practice setting and a written agreement with a physician.

This section shall not be construed as exempting any person from the licensure, registration, permitting and record keeping requirements of this chapter or Chapter 34 of this title.

§ 54.1-3303. Prescriptions to be issued and drugs to be dispensed for medical or therapeutic purposes only.

A. A prescription for a controlled substance may be issued only by a practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled substances, or by a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32 of this title. The prescription shall be issued for a medicinal or therapeutic purpose and may be issued only to persons or animals with whom the practitioner has a bona fide practitioner-patient relationship.

For purposes of this section, a bona fide practitioner-patient-pharmacist relationship is one in which a practitioner prescribes, and a pharmacist dispenses, controlled substances in good faith to his patient for a medicinal or therapeutic purpose within the course of his professional practice. In addition, a bona fide practitioner-patient relationship means that the practitioner shall (i) ensure that a medical or drug history is obtained; (ii) provide information to the patient about the benefits and risks of the drug being prescribed; (iii) perform or have performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically; except for medical emergencies, the

examination of the patient shall have been performed by the practitioner himself, within the group in which he practices, or by a consulting practitioner prior to issuing a prescription; and (iv) initiate additional interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side effects. Any practitioner who prescribes any controlled substance with the knowledge that the controlled substance will be used otherwise than medicinally or for therapeutic purposes shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions of law relating to the distribution or possession of controlled substances.

B. In order to determine whether a prescription which appears questionable to the pharmacist results from a bona fide practitioner-patient relationship, the pharmacist shall contact the prescribing practitioner or his agent and verify the identity of the patient and name and quantity of the drug prescribed. The person knowingly filling an invalid prescription shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions of law relating to the sale, distribution or possession of controlled substances.

No prescription shall be filled unless there is a bona fide practitioner-patient-pharmacist relationship. A prescription not issued in the usual course of treatment or for authorized research is not a valid prescription.

C. A pharmacist may dispense a controlled substance pursuant to a prescription of an out-of-state practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine authorized to issue such prescription if the prescription complies with the requirements of this chapter and Chapter 34 (§ 54.1-3400 et seq.) of this title, known as the "Drug Control Act," except that out-of-state prescriptions are not required to comply with the provisions of subsection A of § 32.1-87 and subsection C of § 54.1-3408 which establish a prescription blank format accommodating the Virginia Voluntary Formulary.

D. A licensed nurse practitioner who is authorized to prescribe controlled substances pursuant to § 54.1-2957.01 may issue prescriptions or provide manufacturers' professional samples for controlled substances and devices as set forth in Chapter 34 of this title in good faith to his patient for a medicinal or therapeutic purpose within the scope of his professional practice.

E. A licensed physician assistant who is authorized to prescribe controlled substances pursuant to § 54.1-2952.1 may issue prescriptions or provide manufacturers' professional samples for ~~Schedule VI~~ controlled substances and devices as set forth in Chapter 34 of this title in good faith to his patient for a medicinal or therapeutic purpose within the scope of his professional practice.

F. A TPA-certified optometrist who is authorized to prescribe controlled substances pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32 of this title may issue prescriptions in good faith or provide manufacturers' professional samples to his patients for medicinal or therapeutic purposes within the scope of his professional practice for the drugs specified on the TPA-Formulary, established pursuant to § 54.1-3223, which shall be limited to oral analgesics included in Schedules III and VI, as defined in §§ 54.1-3450 and 54.1-3455 of the Drug Control Act (§ 54.1-3400 et seq.), when appropriate to relieve ocular pain, and topically applied Schedule VI drugs, as defined in § 54.1-3455 of the Drug Control Act.

§ 54.1-3422. Controlled substances registration certificate required in addition to other requirements; exemptions.

A. Every person who manufactures, distributes or dispenses any substance ~~which~~ *that* is controlled in Schedules I through V or who proposes to engage in the manufacture, distribution or dispensing of any such controlled substance, except permitted pharmacies, those persons who are licensed pharmacists, *those persons who are licensed physician assistants*, and those persons who are licensed practitioners of medicine, osteopathy, podiatry, dentistry, or veterinary medicine, shall obtain annually a controlled substances registration certificate issued by the Board. This registration shall be in addition to other licensing or permitting requirements enumerated in this chapter or otherwise required by law.

B. Registration under this section and under all other applicable registration requirements shall entitle the registrant to possess, manufacture, distribute, dispense, or conduct research with those substances to the extent authorized by this registration and in conformity with the other provisions of this chapter.

C. The following persons need not register and may possess controlled substances listed on

Schedules I through VI:

1. An agent or employee of any holder of a controlled substance registration certificate or of any practitioner listed in subsection A of this section as exempt from the requirement for registration, if such agent or employee is acting in the usual course of his business or employment;

2. A common or contract carrier or warehouseman, or his employee, whose possession is in the usual course of business or employment; or

3. An ultimate user or a person in possession of any controlled substance pursuant to a lawful order of a prescriber or in lawful possession of a Schedule V substance.

D. A separate registration is required at each principal place of business or professional practice where the applicant manufactures, distributes, or dispenses controlled substances.

**2. That the Joint Commission on Health Care shall, with the full cooperation of the Medical Society of Virginia, the Old Dominion Medical Society, the Board of Medicine, the Board of Pharmacy, and physician assistant professional associations, study physician assistant prescriptive authority as provided in this act to determine the impact of the authority to prescribe Schedules IV through VI controlled substances and devices on patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction with physician assistant treatment. A preliminary report on this study shall be provided by the Joint Commission to the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions by July 1, 2004. The Joint Commission shall complete its work in time to submit its written findings and recommendations to the Governor and 2005 General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.**

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# **JOINT COMMISSION ON HEALTH CARE**

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**Executive Director**

Kim Snead

**Senior Health Policy Analyst**

April Kees

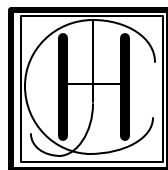
**Health Policy Analyst**

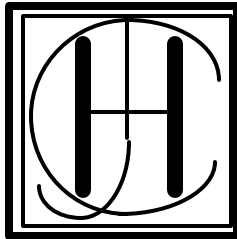
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