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Basic principles to consider when opening a nurse practitioner-owned practice in Texas

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Abstract

Purpose: Advanced Practice Registered Nurse (APRN)-owned clinics in Texas are becoming more common and because of the success of these early clinics, more APRNs are considering opening their own practice; but Texas remains one of the most restrictive states for APRN practice and many questions remain. What are the regulations about physician delegation? Will you get reimbursed from insurance companies and at what rates? Can you be a primary care provider (PCP)?

Data sources: Changes enacted after the adoption of Senate Bill 406 improved the opportunities for APRNs in Texas yet several requirements must be met and early consultation with a lawyer and accountant can facilitate the initial business setup. The Prescriptive Authority Agreement simplified the delegation requirements and allows the APRN increased flexibility in obtaining and consulting with a delegating physician. Becoming credentialed as a PCP with private insurance companies is often complicated; however, utilizing the Council for Affordable Quality Healthcare's Universal Provider Data source for initial credentialing can facilitate this.

Conclusions and implication for practice: Although this article does not discuss the financial implications of opening a practice, it does cover many aspects including legislative and regulatory requirements for practice, credentialing process and challenges, business structure, and tax implications.

The decision to open your own practice

Making the decision to open an independent Advanced Practice Registered Nurse (APRN) Practitioner-owned practice has long been a desire of many APRNs in Texas and has become more common over the past 10 years. According to a recent survey, there are over 200 nurse practitioner-owned clinics in Texas with more on the way (Jacobson, 2013). "Increasing access to primary care is a key focus of health reform in the United States" (Kuo, Loresto, Rounds, & Goodwin, 2013, p. 1236). APRNs are in a unique position to address the primary care needs of Texans. With documented physician shortages, APRNs have the chance to fill the void and improve the health care of our state. However, it may not be as simple as one thinks to open a clinic. A few questions to consider are as follows: What are the regulations about physician delegation? Will you get reimbursed from insurance companies and at what rates? Can you be a primary care provider (PCP)? The purpose of this article is to provide an overview of basic principles the APRN needs to consider when starting an independent practice in the state of Texas.

The role of the Affordable Care Act

"Although the intention of the Affordable Care Act (ACA) is to improve access to primary care for everyone, it will also increase the need for primary care practitioners" (Fontenot, 2014, p. 98). One aspect of the ACA is to make health care less physician-centric and allow APRNs independent practice in the primary care setting. According to Kuo et al. (2013), expanded Medicaid eligibility will increase the need for additional PCPs in Oklahoma, Texas, Georgia, and Louisiana, with only Oklahoma not being in the most restrictive categories of APRN practice.

Legislative review

O'Grady, Hanson, Rudner, and Hodnicki (2012) noted that:

> Over the past 20 years, a series of reports on NP scope of practice have consistently described barriers to NP practice including a wide range of state laws regulating NPs abilities to practice, diagnose illness, and prescribe medication for patients." (p. 1)

The scene is slowly changing for APRNs in Texas thanks to changes enacted by Senate Bill (SB) 406 in the last legislative session. Prior to 2013, APRNs who opened a clinic had to have a delegating physician within 75 miles of the practice site. If that physician moved out of that mileage limit, the APRN had to contract with a new delegating physician immediately or the clinic would have to close. SB 406 removed this restriction and allowed the delegating physician to practice anywhere within the state of Texas and increased the number of APRN physicians may delegate to from four to seven. This, in turn, increases the APRNs' ability to find APRN-friendly physicians to partner with. However, in medically underserved areas and hospital-based practices, there is no limit on the number of APRNs the physician may delegate to.

SB 406 also removed the requirement for the delegating physician to spend any time at the APRN clinic and modified the requirement that 10% of all charts be randomly reviewed by the physician. Under the newly defined Prescriptive Authority Agreement (PAA), the APRN and delegating physician will continue to perform chart reviews on a number they deem appropriate and they will document monthly face-to-face meetings to discuss patient care improvement strategies and need for patient referral (Woolbert & Ziegler, 2013). Meetings for APRNs who have had prescriptive authority for 5 of the last 7 years are required to complete monthly face-to-face meetings for the first year and may then be moved to quarterly meetings via electronic means. APRNs with less experience must complete face-to-face meetings for 3 years prior to moving to quarterly meetings. Face-to-face meetings do not have to take place at the APRN practice site and may take place at a convenient location for both parties.

Prior to 2013, APRNs faced challenges when ordering durable medical equipment (DME) for patients. A significant change implemented by SB 406 is the addition of language allowing APRNs to order nonprescription drugs and DME. The rationale for adding nonprescription drugs is that many drugs have been reclassified by the Food and Drug Administration (FDA) but some health plans, Medicaid, and flexible spending accounts cover some of these with a written prescription. APRNs have been able to prescribe medical devices under the definition of a dangerous drug but Medicaid has not allowed APRNs to sign the Title XIX forms and it is felt that the addition of verbiage delegating medical devices will solve this issue.

Texas, unlike some other states, continues to restrict APRNs from practicing at their full potential and requires physician delegation that has hampered the growth of APRN-owned clinics. According to the American Association of Nurse Practitioners (2014), 20 states have modified regulations on "state practice and licensure law provides for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications—under the exclusive licensure authority of the state board of nursing" (p. 1) or, in other words, allow independent practice. Most notably, Texas is losing APRNs to New Mexico, which allows APRNs to practice independently, and Governor Martinez has "launched a 220,000 dollar nurse practitioner recruiting campaign" (Aaronson, 2013, p. 2). One well-established APRN practice in El Paso moved to New Mexico because of the independent practice environment. Aaronson (2013) noted that Christina Blanco, APRN, moved her practice to New Mexico because she had to pay 25% of clinic profits to her delegating physician and always felt at risk of having to close her practice if the physician backed out of the delegating role.

Prescriptive Authority Agreement

The PAA is a new form created as a result of SB 406 that replaces the previous protocols used in the past. The PAA must contain seven elements and provide a means for quality assurance including face-to-face meetings with the delegating physician. According to the Coalition for Nurses in Advanced Practice (CNAP, 2014), the seven elements required on a PAA are as follows:

- Name, address, and all professional license numbers of parties to agreement
- Nature of practice, practice locations, or practice settings
- Types or categories of drugs or devices the APRN may or may not prescribe
- General plan for consultation and referral
- Plan to address patient emergencies
- General process for communicating information between the APRN and physician
- May designate alternate physicians assuming quality assurance and supervisory duties on a temporary basis
- Describe a prescriptive authority quality assurance plan and specify methods to implement the plan including chart review and face-to-face meetings.

The PAA covers nonprescription drugs, medical equipment, dangerous drugs (antibiotics, diabetes agents, etc.), and controlled substances (narcotics scheduled II–V). Only APRNs practicing in a hospital or hospice may prescribe schedule II narcotics, which now include hydrocodone. Additional restrictions include only prescribing controlled

substances for no more than 90 days and discussing with the delegating physician prior to any controlled substance refill or prescribing to a child two or less. Sample PAA forms can be purchased from the CNAP or Texas Nurse Practitioners at http://www.cnaptexas.org/?page=28 and https://texasnp.site-ym.com/store/ViewProduct.aspx?ID=2290794, respectively. The Texas Academy of Family Physicians has a free PAA form that can be downloaded at http://www.tafp.org/Media/Default/Downloads/news/PAA-sample.pdf.

The APRN is responsible for ensuring that they have an active APRN license with prescriptive authority and for maintaining a valid controlled substance registration (CSR) from the Texas Department of Public Safety (DPS), physician delegation registered with the Texas Medical Board (TMB) and valid Federal Drug Enforcement Registration. Advanced Practice Nurses can verify their license and prescriptive authority on the Texas Board of Nursing website https://www.bon.texas.gov/. Prescribers in Texas must register with the Texas DPS Controlled Substances Division (2014) prior to prescribing controlled substances. According to the Texas DPS, "the purpose of registering these individuals and institutions is to more effectively control the diversion of controlled substances from legitimate channels and to promote public health and welfare by controlling illegal drug trafficking" (p. 1). Applications must be printed and completed by both the APRN and delegating physician. Forms are available for download at http://www.txdps.state.tx.us/InternetForms/Forms/NAR-77A-78A.pdf and must be submitted annually with a $25 processing fee. It is important to note that should the delegating physician change, a modification of registration form must be completed (http://www.txdps.state.tx.us/InternetForms/Forms/NAR-117.pdf) and forwarded to the Texas CSR office; no additional payment is required. It is required that one request the Federal DEA registration after receiving the CSR. Applications for the DEA registration may be found at https://www.deadiversion.usdoj.gov/webforms/jsp/regapps/common/newAppLogin.jsp, be sure and select Form 224 for practitioners. The registration cost is $731 and must be renewed every 3 years, which allows the APRN to provide controlled substances. While completing the CSR, the APRN and delegating physician must simultaneously complete the online delegation registration with the TMB. Both the APRN and physician must create an account and then register a username at the TMB delegation page located at https://sso.tmb.state.tx.us/Login.aspx. The APRN enters the delegating physician's name, license number, and practice location, then the delegating physician approves the delegation. The Texas CSR office will not approve a delegation on their site without the TMB delegation being complete.

Credentialing

Credentialing with insurance companies and local hospitals is a lengthy and challenging task often requiring submission of identical information to multiple sources. Credentialing requirements between payers may vary slightly but be prepared to provide the following basic information:

- Educational background and copies of degrees
- Professional references (at least three)
- Employment history
- Malpractice history including past and current policies and any claims information
- Current license and certification numbers
- Copies of basic or advanced life support
- Tax identification number
- Business name and billing address.

While not exhaustive, having this information readily available will help expedite credentialing. Perhaps the first step in credentialing is to obtain a National Provider Identifier (NPI) enumerator. The NPI is a unique identifier assigned to individual practitioners that is required for credentialing with third-party payers. An NPI application may be completed at https://nppes.cms.hhs.gov/NPPES/Welcome.do. When completing the form be sure to complete the individual provider enrollment and not the organization enrollment.

If the practice intends to accept Medicare patients, separate enrollment is required. Both nonphysicians and physicians complete form CMS 855I – Medicare Enrollment Application for Physicians and Non-Physician Practitioners. The form is a fillable pdf, but may be completed in ink. Medicare prefers electronic completion and submission via the PECOS system, but will accept printed applications that are mailed. As noted above, the first requirement for application is a valid NPI number. The application may be accessed at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855i.pdf.

Medicaid enrollment is controlled at the state level. Enrolling in one program does not automatically enroll a practice into other programs. This is important in practices in Texas that border other states and NPs should understand that each state often has multiple Medicaid contracts with different reimbursement rates. Before enrolling, ask for a fee schedule to review current reimbursement rates for each plan. Table 1 contains application sites for Texas, Louisiana, Arkansas, Oklahoma, and New Mexico Medicaid. Please note that each state prefers online applications but paper copies may be printed and mailed. Processing time ranges from 3 to 12 weeks.

Becoming credentialed with private insurance companies is often complicated and involves multiple steps. For example, enrollment with Blue Cross and Blue Shield

Table 1 Medicaid application sites for Texas, Louisiana, Arkansas, Oklahoma, and New Mexico

Aetna provider enrollment:
https://www.aetna.com/about-aetna-insurance/contact-s/forms/doctors_hospitals/medical_plan.html
Arkansas Medicaid provider enrollment:
https://www.medicaid.state.ar.us/InternetProviderEnrollment/StartAnApplication.aspx
Cigna provider enrollment:
http://www.cigna.com/healthcare-professionals/join-our-network
Humana provider enrollment:
https://www.humana.com/provider/medical-providers/network/learn-more/credentialing
Louisiana Medicaid provider enrollment:
http://www.lmmis.com/provweb1/Provider_Enrollment/PT78_Nurse_Practitioner_Ind.pdf
Oklahoma Medicaid provider enrollment:
https://www.ohcaprovider.com/Enrollment/(S(rmbf22i2d1j2fgkpjbqs1nj3))/Site/Home/Home.aspx
New Mexico Medicaid provider enrollment:
https://nmmedicaid.acs-inc.com/webportal/enrollOnline
Texas Blue Cross Blue Shield:
http://bcbstx.com/provider/network/network_networkparticipation.html
Texas Medicaid provider enrollment:
http://www.tmhp.com/provider_forms/provider%20enrollment/texas%20medicaid%20provider%20enrollment%20application.pdf

Texas (BCBSTX) is slightly more cumbersome. First, a practice must be assigned a BCBSTX Pro Record ID. Then complete and sign a BCBSTX contract agreement and network participation request form. Finally, the practice must already have opened the office site so a site visit by BCBCSTX can be performed. After the site has been approved, the practice can complete the credentialing process online. Be aware that two additional forms must be completed for APRNs. The first form is the Prescribing Authority Supplemental Questionnaire and the second is the Collaborating/Supervising/Monitoring Physician Protocols/Duties/Scope of Practice Supplemental Questionnaire.

It is important to note that BCBSTX requires all providers to utilize the Council for Affordable Quality Healthcare's (CAQH's) Universal Provider Data Source (UPD) for initial credentialing. One benefit of the CAQH UPD is that it is utilized by multiple organizations and once completed, information can be sent electronically to other organizations. Application procedures for Aetna, BCBSTX, Cigna, and Humana are all similar but each has individual requirements and each relies on the CAQH UPD for the majority of credentialing requirements. Links to their provider enrollment sites are provided in Table 1.

It is important for the APRN to become credentialed with local hospitals near the practice location. The majority of hospitals in Texas do not grant APRNs full privileges that would allow them to admit and round on their own patients. Instead, APRNs are granted associate or affiliate privileges that allow the APRN to admit their patient to the delegating physician or to the hospitalist service. Associate or affiliate privileges in some cases allow the APRN to round on their patients but require a cosignature on orders and progress notes. It is important that the admitting physician is aware that the patient will be referred back to the APRN for followup after discharge.

Business guidelines

Business structure

Businesses in Texas are operated in several manners based on individual requirements of the business. According to the Texas Secretary of State (SOS), businesses in Texas typically are one of the following: sole proprietorship, general partnership, corporation, Limited Liability Company, Limited Partnership and Limited Liability Partnership. It is worthy to note that many businesses are designated as an "S" corporation. An "S" corporation is a federal tax election for a for-profit company and has nothing to do with state corporate law. Deciding on whether or not to designate a business as an "S" corporation should be discussed with a tax professional. Deciding on the appropriate business structure should be discussed with legal counsel and an accountant, and it should be made early in the planning process while "taking into consideration issues regarding tax, liability management, continuity, transferability of ownership interests and formality of operation" (Texas SOS, 2014b, p.1). Of all business types, the most common one in health care is the Limited Liability Company (LLC).

Professional LLC

Now that the decision has been made to open an APRN-owned practice, knowledge of basic business principles is essential. In Texas, an LLC is created for the purpose of providing professional services. However, when a license

is required to render that service, a Professional LLC, or PLLC, is formed and requires a certificate of formation. According to the Texas SOS office (2014a), state law stipulates that a PLLC must be formed as "a condition precedent to the rendering of the service, the obtaining of a license in this state" (p. 1) for personal services rendered.

The creation of a PLLC can be handled individually, by a lawyer or multiple online resources including Legal Zoom, Bizfile, and Incfile. Regardless of the method of formation, the steps are similar and consist of the following four articles:

- Article 1—Entity Name and Type—requires the applicant to submit the PLLC name. Proposed names are vetted by the Texas SOS office to ensure the name is not "deceptively similar to, or similar to the name of any existing domestic or foreign filing entity" (Texas SOS, 2014b, p.1) and if they are similar the document will not be filed. It is generally recommended that businesses submit two different names initially to prevent denial of the application.
- Article 2—Registered Agent and Registered Office—requires the applicant to name a domestic or foreign entity registered to do business in Texas or is a resident of the state. It should be noted that the PLLC cannot act as the Registered Agent. The purpose of the Registered Agent is to act on the PLLCs' behalf in receiving legal and tax documentation for the PLLC. The Registered Agent is typically a lawyer or online service such as Legal Zoom.
- Article 3—Governing Authority—requires the PLLC to determine whether or not the PLLC will have officers. If the PLLC will have officers, they must be named and addresses provided on the application. If the PLLC will not have officers, provide the name(s) of the member(s), at least one member is required.
- Article 4—Purpose—the certificate of formation of the PLLC must state the type of professional service rendered by the entity. The Texas Business Organizations Code section 2.004 mandates that a PLLC may only engage in one type of professional service unless given authorization to provide more than one.

Once the application has been completed, a filing fee of $300 to the Texas SOS office and any applicable fees charged by the service filing the application for the PLLC are due. Also, the PLLC must maintain a Registered Agent at all times. If the address of the Registered Agent changes the SOS must be notified in a timely manner. Failure to update the address of the Registered Agent may result in involuntary termination of the professional entity.

Employment taxes

A major difference between being an employee of an organization and practicing as an independent provider is that you are responsible for paying federal and state taxes. Employers pay half of federal income and Medicare taxes but as an independent provider you are responsible for paying "self-employment" taxes that are "similar to the social security and Medicare taxes withheld from the pay of most employees" (Internal Revenue Service, 2014, p. 1). These taxes are due quarterly and after making calculations of estimated taxes, payments may be mailed or paid electronically using the electronic federal tax payment system (EFTPS). An EFTPS account is simple to sign up for and payments are drawn from the company checking or savings account and may be made monthly or quarterly with monthly payments due by the 15th of the month. Tax quarters are aligned to calendar, not fiscal year. Other taxes you are responsible for include both federal and state unemployment taxes.

Reimbursement Issues

Reimbursement is perhaps the most important issue APRNs must address. Although challenges must be overcome for enrolling in insurance networks, failure to accurately document and code patient encounters can cause financial ruin for established and new practices. In order to bill for clinical encounters, Buppert (2006) notes that APRNs must bill for physician and not nursing services. Nursing services are performed in a hospital setting and fall under the prospective payment program. Physician services are billed separately from nursing services and are defined by "diagnosis, therapy, surgery, consultations, and home, office and institutional calls" (Buppert, 2006, p. 224). Office encounters are billed as evaluation and management or procedural codes and must contain the following: comprehensive evaluation, medical diagnosis, and medical decision making.

Craig (2014) noted that APRNs must "clearly understand what Medicare, Medicaid, and private insurance plans and payers require" (p. 16) in order to reduce the number of denied claims. To prevent denied claims, APRNs must also have a working knowledge of the International Classification of Diseases (ICD)—ninth edition, the upcoming 10th edition—and current procedural terminology (CPT) codes for office procedures. Craig (2014) goes on to explain that APRNs must be aware of the provisions in contractual agreements with third-party payers and recommends reviewing each policy's website for current changes and not relying on e-mail or mailed notifications. To help facilitate payments, APRNs need "to submit a clean claim, a billing form that has all of the necessary blanks filled in and answers that conform to the insurer's requirements" (Buppert, 2011, p. 321).

Table 2

National implications

Although the Federal Trade Commission (FTC) has found that "competition among health care providers yields important consumer benefits, as it tends to reduce costs, improve quality, and promote innovation and access to care" (2014, p. 4), APRNs continue to face disadvantages when trying to enter the marketplace because of prohibitive regulations that restrict trade and full practice authority in the majority of states. These restrictions persist despite the fact that America has a nationwide shortage of PCPs with few states worse than Texas. Texas consistently ranks near the bottom for access to primary care either from lack of insurance or, more commonly, lack of access to a PCP. A simple way to alleviate this is to "allow nurse practitioners and physician assistants to provide primary care and reduce restrictions on those practices" (Hammond, 2011).

The Institute of Medicine (IOM) reviewed the role that nursing, in particular APRNs, may offer to address this healthcare shortage and found that APRNs have increased annually by 9% compared to 1% per capita growth by primary care physicians. The FTC noted that APRN "supervision requirements may deprive health care consumers of the many benefits of competition among different types of health care providers," which "may exacerbate provider shortages and thereby contribute to access problems, particularly for underserved populations that already lack adequate and cost-effective primary care services" (2014, p. 20). Restrictions on APRN practice "in some states are the product of politics rather than sound policy" (IOM of the National Academies, 2014, p. 449). These restrictive supervisory laws are directly responsible for the inability of APRNs to fully practice and meet the growing need for primary care services not only in Texas but also throughout the United States. As multiple privately and publicly studies continue to show that APRNs provide safe and quality care, it is important to examine patient outcomes and "determine whether or where legitimate safety concerns exist and, if so, whether physician supervision requirements or other regulatory interventions are likely to address them" (FTC, 2014, p. 4) or if these restrictive supervision requirements are outdated and unjustified. Currently, 19 states and the District of Columbia have reviewed regulatory requirements for APRNS and now allow full practice authority. Florida and Texas have pending legislation that is being debated to increase APRN practice authority.

Summary

The need for increased access to PCPs continues to grow while access to care continues to be limited throughout most of the United States and even more restrictive in Texas. Most barriers can be traced to an ongoing physician shortage and fewer physicians entering primary care in rural areas. Changes enacted by the ACA have presented APRNs with increased opportunities to fill this need. Although this article does not discuss the financial aspects of opening a practice, it does cover many aspects including legislative and regulatory requirements for practice, credentialing process and challenges, business structure and tax implications. It is recommended that consultation with a lawyer or tax professional take place early in the planning process of opening a practice to avoid pitfalls or penalties caused by failure to comply with regulatory laws.

Table 2 provides a flow chart with estimated completion times to consider when opening an APRN-owned practice.

Currently, Texas has two bills before the legislature that may ease the restrictions on nurse practitioner-owned clinics in the state. SB 751 and House Bill 1885 are identical bills that have been filed during the 84th legislative session that would give full practice authority to APRNs in Texas. Should these bills pass, the requirement for physician delegation will no longer be required and the chance for full hospital privileges could become a reality. If Texas passes this legislation, it will join 20 other states and the District of Columbia that grant full practice authority to APRNs.

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