Board Opinion Regarding the Standards of Acceptable and Prevailing Medical Practice for Physicians Involved in Collaborative Agreements with ARNP's

PREAMBLE

In 1996, the Kentucky General Assembly amended the Nursing Practice Act, KRS Chapter 314, to grant authority to Advanced Registered Nurse Practitioner's (ARNPs) to prescribe legend medications under specified circumstances. In 2006, the General Assembly extended this prescriptive authority for ARNPs to include the authority to prescribe controlled substances under specified circumstances.

The statutes authorizing these professional actions by ARNPs and outlining the legal requirements for such actions are KRS 314.011(8) and 314.042(8) and (9). Among other things, each of these statutes require that, before an ARNP may prescribe medications under the statute, the ARNP must enter into a written collaborative agreement with a physician "that defines the scope of the prescriptive authority for" the medications – nonscheduled and scheduled drugs.

The Kentucky Medical Association, on behalf of its members, has asked the Board to issue this opinion to provide guidance to any physician who intends to enter into or does enter into a collaborative agreement with an ARNP to permit the ARNP to prescribe legend medication or to prescribe controlled substances. In order to help educate physicians who do not have ready access to the Kentucky Revised Statutes, particularly KRS Chapter 314 relating to nursing practice, the Board will quote relevant provisions relating to physician actions as part of this opinion. The Board will also set out its position on the minimum standards of acceptable and prevailing medical practice for physicians entering into collaborative agreements with ARNPs in the Commonwealth of Kentucky.

Physicians who are licensed in Kentucky are subject to disciplinary action by this Board upon proof that they have violated any provision of KRS 311.595. Under KRS 311.595(9), as that term is illustrated by KRS 311.597(4), a physician's license may be disciplined by this Board if the physician engages in conduct which departs from, or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth.

If a grievance is filed against your Kentucky medical license for conduct relating to your participation in a collaborative agreement, the Board will consider whether you have complied with these standards and have properly documented your actions. In determining whether disciplinary action is appropriate, the Board will also consider expert testimony regarding the standards of acceptable and prevailing medical practice in this area. As with any other practice standard, the Board recognizes that there may be unique circumstances that warrant deviation from these standards. If you believe that such a circumstance exists in a particular case, you should fully document that circumstance and your reason for acting in a manner that deviates from these standards.

Physicians who are not licensed to practice in Kentucky, but who engage in the practice of medicine in this state, may be subject to criminal prosecution under KRS 311.565.

LEGAL AUTHORITY

This is a Board opinion issued pursuant to the Board's statute, KRS 311.602, to assist licensees in determining what actions would constitute unacceptable conduct under the provisions of KRS 311.595. The Board has decided to publish this opinion because it addresses issues of significant public and medical interest.

This opinion is not a statute or administrative regulation, and does not have the force of law.

STANDARDS OF ACCEPTABLE AND PREVAILING MEDICAL PRACTICE RELATING TO A PHYSICIAN'S INVOLVEMENT IN A COLLABORATIVE AGREEMENT, IN GENERAL

The Board has determined that the following principles constitute the standards of acceptable and prevailing medical practice relating to a physician's conduct in a collaborative agreement. In making this determination, the Board has considered the relevant statutes (which are quoted as appropriate), practice standards relating to physician's conduct and interactions with other health care professionals and basic practice standards.

STATUTORY REQUIREMENTS

As an initial matter, each physician who considers entering into or actually enters into a collaborative agreement with an ARNP should know the legal requirements for each party.

I. FOR NONSCHEDULED LEGEND DRUGS – KRS 314.042(8)

Before an advanced registered nurse practitioner engages in the prescribing or dispensing of nonscheduled legend drugs as authorized by KRS 314.011(8), the advanced registered nurse practitioner shall enter into a written "Collaborative Agreement for the Advanced Registered Nurse Practitioner's Prescriptive Authority for Nonscheduled Legend Drugs" (CAPA-NS) with a physician that defines the scope of the prescriptive authority for nonscheduled legend drugs. (Emphasis added)

II. FOR CONTROLLED SUBSTANCES – KRS 314.042(9)

Before an advanced registered nurse practitioner engages in the prescribing of Schedule II through V controlled substances as authorized by KRS 314.011(8), the advanced registered nurse practitioner shall enter into a written "Collaborative Agreement for the Advanced Registered Nurse Practitioner's Prescriptive Authority for Controlled Substances" (CAPA-CS) with a physician that defines the scope of the prescriptive authority for controlled substances.

(a) The advanced registered nurse practitioner shall notify the Kentucky Board of Nursing of the existence of the CAPA-CS and the name of the collaborating physician and, upon request, furnish to the board or its staff a copy of the completed CAPA-CS. The Kentucky Board of Nursing shall notify the Kentucky Board of Medical Licensure that a CAPA-CS exists and furnish the collaborating physician's name.

(b) The CAPA-CS shall be in writing and signed by both the advanced registered nurse practitioner and the collaborating physician. A copy of the completed collaborative agreement shall be available at each site where the advanced registered nurse practitioner is providing patient care.

(c) The CAPA-CS shall describe the arrangement for collaboration and communication between the advanced registered nurse practitioner and the collaborating physician regarding the prescribing of controlled substances by the advanced registered nurse practitioner.

(d) The advanced registered nurse practitioner who is prescribing controlled substances and the collaborating physician shall be qualified in the same or a similar specialty.

(e) The CAPA-CS is not intended to be a substitute for the exercise of professional judgment by the advanced registered nurse practitioner or by the collaborating physician.

(f) Before engaging in the prescribing of controlled substances, the advanced registered nurse practitioner shall:

1. Have been registered to practice as an advanced registered nurse practitioner for (1) year with the Kentucky Board of Nursing; or
2. Be nationally certified as an advanced registered nurse practitioner and be registered, certified, or licensed in good standing as an advanced registered nurse practitioner in another state for one (1) year prior to applying for licensure by endorsement in Kentucky.

(g) Prior to prescribing controlled substances, the advanced registered nurse practitioner shall obtain a Controlled Substance Registration Certificate through the U.S. Drug Enforcement Agency.

(h) The CAPA-CS shall be reviewed and signed by both the advanced registered nurse practitioner and the collaborating physician and may be rescinded by either party upon written notice via registered mail to the other party, the Kentucky Board of Nursing, and the Kentucky Board of Medical Licensure.

(i) The CAPA-CS shall state the limits on controlled substances which may be prescribed by the advanced registered nurse practitioner, as agreed to by the advanced registered nurse practitioner and the collaborating physician. The limits so imposed may be more stringent than either the schedule limits on controlled substances established in KRS 311.011(8), or the limits imposed in regulations promulgated by the Kentucky Board of Nursing thereunder

III. KRS 314.011(8) ARNP's authorization to issue prescriptions

...Advanced registered nurse practitioners who engage in these additional acts shall be authorized to issue prescriptions for and dispense nonscheduled drugs as defined in KRS 217.905 and to issue prescriptions for but not to dispense Schedule II through V controlled substances as classified in KRS 218A.060, 218A.070, 218A.080, 218A.090, 218A.100, 218A.110, 218A.120, and 218A.130, under the conditions set forth in KRS 314.042 and regulations promulgated by the Kentucky Board of Nursing on or before August 15, 2006.

(a) Prescriptions issued by advanced registered nurse practitioners for Schedule II controlled substances classified under KRS 218A.060 shall be limited to a seventy-two (72) hour supply without any refill. Prescriptions issued under this subsection for psychostimulants may be written for a thirty (30) day supply only by an advanced registered nurse practitioner certified in psychiatric-mental health nursing, who is providing services in a health facility as defined in KRS Chapter 216B or in a regional mental health-mental retardation services program as defined in KRS Chapter 210.

(b) Prescriptions issued by advanced registered nurse practitioners for Schedule III controlled substances classified under KRS 218A.080 shall be limited to a thirty (30) day supply without any refill. Prescriptions issued by advanced registered nurse practitioners for Schedules IV and V controlled substances classified under KRS 218A.100 and 218A.120 shall be limited to the original prescription and refills not to exceed a six (6) month supply.

...

IV. 201 KAR 20:059 The Administrative Regulation Governing Controlled Substances Prescriptions

This administrative regulation imposes specific limitations upon certain medications prescribed by ARNPs under collaborative agreements.
Prescriptions for the following Schedule IV medications shall be limited to a 14-day supply without any refills:

Diazepam (Valium)
Clonazepam (Klonopin)
Lorazepam (Ativan)
Alprazolam (Xanax)

Prescriptions for Carisprodol (Soma), a Schedule IV medication shall be limited to a 30-day supply without any refills.
Prescriptions for Combination Hydrocodone products in liquid or solid dosage form, Schedule III medications, shall be limited to a fourteen (14) day supply without any refills.

The basic statutory requirement for each type of collaborative agreement is that the agreement must define the scope of the prescriptive authority of the nurse practitioner.

Therefore, before entering into the collaborative agreement, the physician and nurse practitioner must address and come to a mutual agreement about the scope of that prescriptive authority and the terms of the collaborative agreement. It is like a contract – to be a valid and workable agreement, there must be mutual understanding and agreement between the parties. The scope of the prescriptive authority and the terms of the collaborative agreement define the roles of the physician and the nurse practitioner and establish the frequency and levels of professional judgment that must be exercised by each party.

SCOPE OF PRESCRIPTIVE AUTHORITY

The scope of the prescriptive authority set out in the collaborative agreement will essentially define the physician's role and the frequency and extent of the physician's contact with and interaction with the nurse practitioner regarding the use of the medications covered. There are several possible models of collaborative arrangements; some of the models are listed here in order of decreasing autonomy for the nurse practitioner:

1. The parties agree that the nurse practitioner will have full authority to prescribe any medications in the class. The nurse practitioner will only consult with the physician when the nurse practitioner determines that such consultation is necessary.
2. The parties agree to limit the nurse practitioner's prescriptive authority to specific medications in the class or to exclude certain medications in the class. The nurse practitioner will only consult with the physician when the nurse practitioner determines that such consultation is necessary.
3. The parties agree that the nurse practitioner will have full authority to prescribe any medications in the class. The parties further agree that the nurse practitioner will consult with the physician in a manner and on a schedule determined by the parties.
4. The parties agree to limit the nurse practitioner's prescriptive authority to specific medications in the class or to exclude certain medications in the class. The parties further agree that the nurse practitioner will consult with the physician in a manner and on a schedule determined by the parties.
5. The parties agree that the nurse practitioner will have full authority to prescribe any medications in the class. The parties agree that the nurse practitioner will consult with the physician in a manner and on a schedule determined by the parties. Finally, the parties agree that such consultation will be supplemented with periodic charts reviews conducted by the physician in a manner and on a schedule determined by the parties.
6. The parties agree to limit the nurse practitioner's prescriptive authority to specific medications in the class or to exclude certain medications in the class. The parties further agree that the nurse practitioner will consult with the physician in a manner and on a schedule determined by the parties.
7. The parties agree that the nurse practitioner will have full authority to prescribe any medications in the class. The parties further agree that the nurse practitioner

will consult with the physician on each prescription and that the physician will conduct a chart review on each patient.

8. The parties agree to limit the nurse practitioner's prescriptive authority to specific medications in the class or to exclude certain medications in the class. The parties further agree that the nurse practitioner will consult with the physician on each prescription and that the physician will conduct a chart review on each patient..

While not an exhaustive listing, the Board recommends that each physician consider, at a minimum, the following information when determining the nature of a collaborative agreement with and scope of prescriptive authority for each specific nurse practitioner:

1. The physician's ability to effectively assess the nurse practitioner's professional ability to appropriately prescribe or dispense the medications in that class;
2. The physician's personal knowledge of and ability to observe the nurse practitioner's practice;
3. The nurse practitioner's scope of practice;
4. The nurse practitioner's patient population;
5. The nurse practitioner's educational training relating to the specific class of medications;
6. The nurse practitioner's professional experience in a setting which utilizes the specific class of medications;
7. The physician's professional confidence in the degree of discretion being allotted to the nurse practitioner under the collaborative agreement;
8. The physician's knowledge of and experience with the medications being authorized by the collaborative agreement; and
9. The geographic locations of the physician's practice and the nurse practitioner's practice, and their capacity to consult in a meaningful manner.

KRS 314.042(9), the statute relating to Collaborative Agreements for Controlled Substances (CAPA-CS) expressly requires the collaborating physician to be qualified in the same or a similar specialty as the nurse practitioner. While there is not a similar statutory requirement for CAPA-NS, the Board recommends that physicians consider whether they want to voluntarily impose the same restriction in Collaborative Agreements for Nonscheduled Drugs (CAPA-NS)

In determining the scope of the prescriptive authority, the Board recommends the physician specifically consider the nurse practitioner's scope of practice and the medications that the nurse practitioner would be expected to prescribe or dispense as part of that practice. The Board recommends the physician then consider whether to limit the scope of the prescriptive authority expressly to those medications as part of the collaborative agreement. If the physician determines to limit the scope of the nurse practitioner's prescriptive authority, such limitation should be clear in the collaborative agreement – either a specific list of medications authorized or a specific list of medications excluded under the agreement. As an alternative to absolute limitation, the physician may want to authorize the use of specific medications on the condition that, before prescribing or dispensing that specific medication, the nurse practitioner must first consult with the physician about the use of that medication for that patient under the specific circumstances.

The physician may also consider a phasing process for collaborative agreements. Under this process, the physician and nurse practitioner may initially enter into a collaborative agreement that either limits the prescriptive authority or includes increased physician involvement. After the parties reach a certain comfort level, they could then execute a new collaborative agreement, which decreases or removes limits and decreases or removes regular physician involvement. The parties can work through this process until they reach the collaborative agreement that is appropriate for their situation.

LIMITATION UPON PRESCRIPTIVE AUTHORITY FOR CONTROLLED SUBSTANCES

The applicable statute, KRS 314.042(9)(i), states specifically,

> The CAPA-CS shall state the limits on controlled substances which may be prescribed by the advanced registered nurse practitioner, as agreed to by the advanced registered nurse practitioner and the collaborating physician. The limits so imposed may be more stringent than either the schedule limits on controlled substances in KRS 314.011(8), or the limits imposed in regulations promulgated by the Kentucky Board of Nursing thereunder.

In order to decide what limits to place on the nurse practitioner's prescribing of controlled substances, and whether those limits should be more stringent than those imposed by administrative regulation, it is critical for the parties to know and understand the minimum limits imposed by statute and administrative regulation.

KRS 314.011(8) establishes the following limits,

- Schedule II: a 72-hour supply with no refills
- Schedule II Psychostimulants: a 30 day supply if ARNP is certified in psychiatric-mental health nursing and is providing services in a health facility as defined in KRS Chapter 216B or in a regional mental health-mental retardation services program as defined in KRS Chapter 210
- Schedule III generally: 30 day supply with no refills
- Schedule III hydrocodone products in liquid or solid dosage form: 14 day supply with no refills
- Schedule IV and V generally: original prescription and appropriate refills for a total period not to exceed 6 months.
- Schedule IV specifically. The following Schedule IV medications are limited to a 14-day supply with no refills:
  - Diazepam (Valium)
  - Clonazepam (Klonopin)
  - Lorazepam (Ativan)
  - Alprazolam (Xanax)
- Carisprodol (Soma) is limited to a 30 day supply with no refills

As noted, the statute and the administrative regulation fix these limits. However, as part of the collaborative agreement, the physician and nurse practitioner may agree to

limit the permissible supply to a shorter period. In addition, the physician and nurse practitioner may agree to limit the controlled substances prescribing further by excluding certain controlled substances under the collaborative agreement.

If the physician believes that specific limits are appropriate based upon the information available and upon the physician's professional judgment, but the nurse practitioner will not agree to those limits, that simply means that there is not a "meeting of the minds" and the physician should not enter into that specific collaborative agreement.

Finally, the Board of Nursing has taken the position that, while the statute and administrative regulation specify certain time limits with no refills, the statute does not prohibit the nurse practitioner from writing new prescriptions for that medication. For example, while the statute limits Schedule II prescriptions to a 72-hour supply with no refills, the Board of Nursing position would allow the nurse practitioner to write successive 72-hour prescriptions for Schedule II substances for as long a period as determined appropriate by the nurse practitioner. If the physician does not agree with this interpretation of the limits or believes that the limits should be more stringent than that, the physician should insist on a clear statement of the limits in the collaborative agreement.

OTHER TERMS AND ISSUES

Separate Agreement for Nonscheduled and Scheduled Drugs

Under KRS 314.042, the nurse practitioner must enter into a specific collaborative agreement, a CAPA-NS, with a physician in order to prescribe or dispense nonscheduled legend drugs. If the nurse practitioner wishes to prescribe scheduled drugs, the nurse practitioner and physician must enter into a specific collaborative agreement, CAPA-CS, to do so.

A physician may choose to enter both of these agreements with a nurse practitioner who chooses to prescribe all classes of medications. Or, the physician may choose to enter into one, but not the other, collaborative agreement. In similar fashion, physicians should be aware that a nurse practitioner may choose to execute one type of agreement with one physician, but the other type with a different physician. If the physician becomes aware of such an arrangement, the physician must determine whether it is professionally appropriate to only collaborate with a particular nurse practitioner for one type of medication.

Terms of the Collaborative Agreements

The statutes, KRS 314.011 and 314.042, require more terms and more specific requirements for collaborative agreements involving controlled substances (CAPA-CS) than for collaborative agreements involving nonscheduled legend drugs (CAPA-NS). The physician should read the statute to ensure that all of the physician's statutory requirements are met. The Board recommends that a physician who is considering entering into a collaborative agreement with a nurse practitioner for nonscheduled legend drugs (CAPA-NS) read the requirements for a collaborative agreement for controlled

substances (CAPA-CS) and determine whether any of those terms should be included or addressed in the CAPA-NS.

CAPA-NS Terms

The statute relating to collaborative agreements for nonscheduled legend drugs, KRS 314.042(8), sets out two requirements:

- it must be written; and,
- it must define the scope of the prescriptive authority for nonscheduled legend drugs.

CAPA-CS Terms

The statute relating to collaborative agreements for scheduled drugs, KRS 314.042(9), sets out the following minimum requirements:

- it shall be in writing;
- it shall be reviewed and signed by both the nurse practitioner and the physician;
- it shall describe the arrangement for collaboration and communication between the nurse practitioner and the physician regarding the prescribing of controlled substances by the nurse practitioner;
- the nurse practitioner and the physician must be qualified in the same or a similar specialty; and,
- it shall state the limits on controlled substances which may be prescribed by the nurse practitioner, as agreed by the nurse practitioner and the physician.

Reporting and Retention of the CAPA-CS

The nurse practitioner shall notify the Kentucky Board of Nursing of the existence of the CAPA-CS and the name of the collaborating physician. Upon request, the nurse practitioner shall furnish to the Board of Nursing a copy of the completed CAPA-CS. The Board of Nursing will notify the Board of Medical Licensure (KBML) that a CAPA-CS exists and furnish the collaborating physician's name to KBML. NOTE: There is no similar reporting requirement for a CAPA-NS.

A copy of the CAPA-CS must be available at each site where the nurse practitioner is providing patient care. NOTE: There is no similar requirement for a CAPA-NS.

While there is no requirement for the physician to retain a copy of the agreement, the Board would encourage each physician involved in a collaborative agreement to retain and use a copy of each agreement. If the physician is contacted by the nurse practitioner for collaboration or consultation, the physician should be able to refer to the agreement to: a) recall the scope of the prescriptive authority, including any limits; and, b) ensure that collaboration or consultation is taking place as agreed and in the manner agreed to. If the Board receives and investigates a grievance relating to the physician's involvement in or conduct relating to the agreement, the Board's investigator will want to see a copy

of the collaborative agreement and discuss its terms and the compliance with those terms with the physician.

Termination of the CAPA-CS

The CAPA-CS may be rescinded by either party. The party rescinding the CAPA-CS must do so by written notice via registered mail to:

- the other party;
- the Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky 40222; and,
- the Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222.

Same or Similar Specialty

The statutory provisions for a CAPA-CS (KRS 314.042(9)(d)) specify that the nurse practitioner and the collaborating physician must be qualified in the same or similar specialty. While not required by statute, the Board recommends that a physician who is considering entering into a collaborative agreement for nonscheduled legend drugs, CAPA-NS, consider whether it is appropriate to enter into such an agreement if the physician is not qualified in the same or similar specialty as the nurse practitioner. The physician must determine, and will be assessed upon, whether they can appropriately define the prescriptive authority for and appropriately collaborate with a nurse practitioner who is not qualified in the physician's specialty or a similar specialty.

In a similar vein, a physician who is no longer engaged in the full-time active practice of medicine should consider whether it is professionally appropriate to enter into or to continue in a collaborative agreement. The physician should consider the length of time since they have been involved in the full-time active practice of medicine. The physician should also consider the amount of time spent in their practice dealing with the issues expected to arise relating to prescribing of the specific medications covered by such an agreement.

Method of Collaboration

For a CAPA-CS, KRS 314.042(9)(c) requires that such agreement must describe the arrangement for collaboration and communication between the nurse practitioner and the physician. While the statute addressing collaborative agreements for nonscheduled legend drugs (CAPA-NS) does not include this requirement, it would be professionally appropriate for a physician entering into a CAPA-NS to address this issue with the nurse practitioner and outline such arrangement in the CAPA-NS.

There may be occasions where a nurse practitioner asks a physician to enter into a collaborative agreement even though the two practitioners' practices are located a significant distance from each other. In those instances, the physician must determine whether it would be professionally appropriate to enter into such an agreement. In making this determination, the physician should consider, among other things,

- the actual physical distance between the practices;

- the normal business hours of the respective practices;
- whether the normal means of collaboration or consultation under the agreement are intended to involve personal (face-to-face) interaction or whether such collaboration or consultation is intended to take place exclusively by telephone or by electronic communications. As part of this consideration, the physician must determine whether the format of the expected collaboration or consultation meets professional standards and is sufficient;
- the physician's expected role in the event a patient experiences an adverse reaction to a medication prescribed by the nurse practitioner, particularly whether the physician would be expected to respond and attend to the affected patient or to admit the affected patient to a hospital at which the physician would need to have privileges; and,
- the physician's ability to physically travel to the location of the nurse practitioner's practice or to an affected patient.

If, after considering these various factors and other information available, the physician determines that it would not be possible to meet the physician's professional responsibilities under such an agreement, the physician should not enter into the agreement.

The physician should also consider and address with the nurse practitioner, before entering into the collaborative agreement, the necessity of collaboration or consultation during periods when the physician is unavailable. If so, the physician should consider and address with the nurse practitioner the means for collaboration or consultation during those periods. As part of this consideration, the physician and the nurse practitioner should determine whether it would be appropriate to arrange for an alternate physician to collaborate or consult with the nurse practitioner during those periods. If so, the identity of the alternate physician and the means of collaborating or consulting with the alternate physician should be stated in the collaborative agreement.

Number of Collaborative Agreements

The physician may be asked to enter into collaborative agreements with a number of nurse practitioners. The physician must determine whether the physician can meet professional responsibilities if the physician enters each collaborative agreement the physician is invited to enter. In making this determination, a physician should note that, under KRS 311.854, a physician may only supervise 2 physician assistants; however, this is tempered by the differences in the levels of involvement by the physician. Supervision of a physician assistant is designed to be a full-time endeavor. On the other hand, the physician's involvement in a collaborative agreement is typically confined to the initial determination of the nature of the collaborative agreement, including defining the scope of the prescriptive authority, and the time spent in the collaboration or consultation on prescribing issues required under the collaborative agreement. In making this determination, it is appropriate for the physician to recognize that collaborative agreements are expressly limited to prescribing by a nurse practitioner and does not involve their other professional acts.

Physician in Good Standing

Under KRS 311.854(2)(a), physicians are prohibited from supervising physician assistants if the physician is subject to any order or agreed order issued by the Board of Medical Licensure. There is no similar statutory prohibition relating to a physician entering into a collaborative agreement.

However, the Board urges any physician who is subject to an order or agreed order issued by the Board to strongly consider whether it would be professionally appropriate for the physician to enter into such an agreement and to collaborate or consult with a nurse practitioner on prescribing issues. A physician should recognize that the Board will question very seriously the professional appropriateness of a physician entering into such an agreement when the physician is subject to a Board order based upon standard of care violations, particularly violations relating to the physician's competence to prescribe medications including controlled substances.

If a physician becomes subject to a Board order after entering into a collaborative agreement(s), the Board recommends that the physician determine whether continued participation in the agreement is professionally appropriate. If the physician determines that it would not be professionally appropriate to continue in the collaborative agreement, the agreement should be rescinded pursuant to the procedure set out in the statute.

Request for Individual Opinion

If a physician has a specific question about entering into or participation in a collaborative agreement, the physician may request a Board opinion addressing the specific issue(s). It is within the Board's discretion whether or not to issue such an opinion.