State Policy Update

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Occupational Therapy Association of Oregon Meets With the Department of Human Services

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In accordance with House Bill 2345, the Department of Human Services (DHS) was tasked with establishing an Impaired Health Professionals Program to monitor Licensees in health professions who are unable to practice safely and competently due to a mental health or substance abuse disorder. Rules OAR 415-065, if adopted, would implement this program in the state of Oregon. Upon review of these rules and in consultation with occupational therapy mental health practitioners and the Oregon Occupational Therapy Licensing Board (OTLB), the Legislative Division of the Occupational Therapy Association of Oregon (OTAO) submitted a letter to the rules coordinator with multiple concerns.

As defined by House Bill 2345, "'Impaired Professional' means a licensee who is unable to practice with professional skill and safety by reason of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability or by reason of a mental health disorder." Rules OAR 415-065 did not include a definition of "impaired professional." This aside, the definition raised civil rights concerns, as there were fears that individuals identified as having a substance abuse or mental health disorder would have to involuntarily participate in a monitoring program. Furthermore, it was thought that having specified mental health and substance abuse disorders exclusively in this definition was discriminatory against these individuals, despite the fact that other health conditions could have an effect on professional performance and safety.

In addition, the rules implied that all individuals being monitored under this program would have to participate in random toxicology screens even with no prior history of substance abuse. It also did not specify a course of action for individuals identified who are already involved in a program implemented by their professional licensing board. OTAO strongly suggested that these points be clarified before any rules were adopted. Finally, there was concern over the potential expenses for individuals and their licensing boards should a program such as this be implemented and mandated.

These concerns were addressed in a meeting between OTAO Legislative Co-Chair Tiffany Boggis and Darcy Edwards, Addictions and Mental Health Manager for this program. OTAO lobbyist John McCulley also provided testimony at the rule hearing. As a result OAR 415-065-0005 was changed to ensure that just by having a diagnosis of mental health disorder or substance abuse disorder does not mean these individuals are automatically considered an "impaired professional." It was also clarified that impaired professionals sign consent to take part in the program and therefore are not required to participate against their will. In regards to toxicology testing and expense concerns there were no changes made. The Oregon Medical Board, the Board of Nursing, Pharmacy Board, and the Board of Dentistry are currently the only Oregon state health boards participating in this program.

As a result, OAR 415-065-0005 was changed to ensure that just by having a diagnosis of mental health disorder or substance abuse disorder does not mean these individuals are automatically considered an "impaired professional."

Karen Hass, OTR/L, is the Legislative Co-chair for the Occupational Therapy Association of Oregon.

Georgia Occupational Therapy Association Addresses Pediatric Medicaid Issues

Tom Bauer

The Georgia Occupational Therapy Association (GOTA) along with pediatric speech therapists and physical therapists in Georgia continue to confront difficulties in securing services for patients with disabilities in the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) portion of the Medicaid program. EPSDT and its rules require that children receive "medically necessary" services, regardless of whether a particular treatment is available under a state's general Medicaid program. These problems increased when the state of Georgia converted to a managed care system and contracted with three health management organizations, known as CMOs (care management organizations) in Georgia.

Initially, therapists experienced a nightmare of paperwork involved in requesting prior approval (PAs) of services prescribed by a physician because the state set the "trigger" for PAs so low that nearly every child required prior approval. The state had steadily moved from allowing ten treatments to two before PAs were required.

As a result, a tri-alliance of pediatric occupational therapy practitioners, speech therapists, and physical therapists successfully advocated for passage of legislation in 2007, which was vetoed, and a follow-up bill (SB 507) that passed and was signed in 2008. These bills were intended to address problems such as denial of medical services, service delays leading to medical complications, and a lack of providers as therapists no longer participated in Medicaid (in part due to extensive paperwork requirements). Some of the key requirements of SB 507 bill were:

- Requiring Medicaid to adhere to the federal definition (as opposed to managed care standards) of "medically necessary" for children in the EPSDT program;
- Clarifying that services to, "correct or ameliorate a child's condition need not have to result in improvement" (e.g. child's condition may be maintained or prevented from deterioration);
- Authorizing PAs for services of up to 6 months for chronic conditions.

Whereas some of these problems and others under the Aged, Blind, and Disabled section of Medicaid have been cleared up, pediatric occupational therapy practitioners and the parents of their clients have experienced extensive problems in dealing with the CMOs, despite passage of the legislation. Among the problems that have continued are:

- Automatic halving in approval of requested services (SB 507 requires services of up to 6 months, based upon the "individual needs of the child");
- Required standardized testing, despite the fact that in some cases no test exists or the child's condition precludes testing;
- Denial of services as duplicative with special education services, despite the difference in goals of a child's individualized education plan and the plan of care under EPSDT;
- Routine delays in credentialing and adding new providers to the network.

These practices are perhaps a result of CMOs being paid a capitated amount, which some suspect encourages CMOs to cut corners. The practices create problems for parents in accessing care for their children with disabilities or result in denials or delays of treatment, which lessen progress made in previous treatment.

The Georgia Occupational Therapy Association and AOTA would like to know if pediatric occupational therapy practitioners in other states have experienced similar problems with Medicaid programs.

Tom Bauer is the Lobbyist/Legislative Liaison for the Georgia Occupational Therapy Association.

The American Occupational Therapy Association's

State Affairs Group

Purpose

The State Affairs Group is responsible for all of the Association's state legislative and regulatory activities. This department monitors and provides analysis of proposed legislation and regulations affecting occupational therapy in the states, conducts outreach and provides assistance to state OT associations on key state issues such as professional regulation/scope of practice. The department also provides day-to-day liaison with state OT regulatory boards on professional trends and issues such as supervision and continuing competence requirements.

Resources

Department staff provide research, technical assistance, and consultation on a wide range of state legislative and regulatory issues, and function as a clearinghouse for information useful to state regulatory boards. Staff members work with the state regulatory boards, analyze proposed legislation and regulations on key issues, provide testimony and recommend appropriate strategies for handling issues that affect the profession.

Staff and Contact Information

Please contact us if there are any issues that you would like to learn more about or require technical assistance. The department also invites suggestions for future newsletter articles.

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Guidance for the Supervision of Level II Fieldwork Students

AOTA's Commission on Practice and Commission on Education Joint Task Force recently developed the *Practice Advisory: Services Provided by Students in Fieldwork Level II Settings* to provide guidance for the supervision of Level II fieldwork students providing occupational therapy services under a qualified occupational therapist or occupational therapy assistant. The *Practice Advisory: Services Provided by Students in Fieldwork Level II Settings* was approved by AOTA's Representative Assembly during its online meeting, held from November 8 to 15. The practice advisory may be viewed at www.aota.org /meetingslibrary/fallra/practice and is provided in its entirety below.

When adhering to the principles stated below, along with other regulatory and payer requirements, AOTA considers that students at this level of education are providing skilled occupational therapy intervention.

Practice Advisory: Services Provided by Students in Fieldwork Level II Settings

Level II fieldwork students may provide occupational therapy services under the supervision of a qualified occupational therapist or occupational therapy assistant in compliance with state and federal regulations.

When adhering to the principles stated below, along with other regulatory and payer requirements, AOTA considers that students at this level of education are providing skilled occupational therapy intervention.

General Principles:

a. Supervision of occupational therapy and occupational therapy assistant students in Fieldwork Level II settings should ensure protection of consumers and provide opportunities for appropriate role modeling of occupational therapy practice.
b. To ensure safe and effective occupational therapy services, it is the responsibility of the supervising occupational therapist and occu-pational therapy assistant to recognize when supervision is needed and ensure that supervision supports the student's current and developing levels of competence with the occupational therapy process.
c. In all cases the occupational therapist is ultimately responsible for all aspects of occupational therapy service delivery and is accountable for the safety and effectiveness of the occupational therapy service delivery process. This would include provision of services provided by an occupational therapy assistant student under the supervision of an occupational therapy assistant (see Addendum 1).
d. Initially, supervision should be in line of sight and gradually decrease to less direct supervision as is appropriate depending on the (ACOTE, 2007a.; b.& c.):
   - Competence and confidence of the student,
   - Complexity of client needs,
   - Number and diversity of clients,
   - Role of occupational therapy and related services,
   - Type of practice setting,
   - Requirements of the practice setting, and
   - Other regulatory requirements.

In settings where occupational therapy practitioners[1] are employed:

- Occupational therapy students should be supervised by an occupational therapist.
- Occupational therapy assistant students should be supervised by an occupational therapist or occupational therapy assistant in partnership with an occupational therapist.

In settings where occupational therapy practitioners are not employed:

- Students should be supervised by another professional familiar with the role of occupational therapy in collaboration with an occupational therapy practitioner.

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Prepared by:
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1 When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2006).

Focusing on Scopes of Practice

Marcy M. Buckner

Capital Briefing, OT Practice *Magazine, December 20, 2010*

The American Medical Association (AMA) scope-of-practice initiative, the adoption of federal health care reform, and increased interest in state licensure by additional health care providers have prompted a resurgence of attention on the scopes of practice of health care professionals. With health care reform expected to increase the number of insured Americans by 32 million, resulting in an attendant increase in demand for health care services, reviewing—and possibly expanding—health care professionals' scopes of practice may be needed to ensure adequate health care for all of these newly insured.

AMA's scope of practice initiative includes the creation of reports called the "Scope of Practice Data Series," which review and analyze the qualifications and practices of 10 categories of "non-physician" health care professionals according to the AMA's perspective. The AMA's initiative is an effort to restrict the practice of health care professionals who are not doctors of medicine (MDs) or osteopathy (DOs), and as a result would limit patient access to safe, high-quality, and cost-effective health care by non-physician practitioners.

Coalition for Patients' Rights

To ensure that the growing needs of the American health system can be met and that patients everywhere have access to quality health care providers of their choice, more than 35 organizations, including AOTA, have formed the Coalition for Patients' Rights (CPR). In representing a variety of licensed health care professionals who provide safe, effective, and affordable health care services to millions of patients each year, CPR seeks to counter efforts by the AMA Scope of Practice initiative and other issues that could lead to limits on patients' choice of health practitioners and, by extension, hinder creation of the best possible health care system.

What specifically is "scope of practice"? CPR defines scope of practice as "the range of health care-related activities and services that a health care professional is educated, and certified or licensed, to provide." The Citizen Advocacy Center (CAC), which provides training, research, and other support to public members of health professional oversight bodies, defines scope of practice in laymen's terms as "who can do what to whom, under what conditions, and in what settings."

At CAC's recent annual meeting, which included AOTA staff and a CPR representative, scope of practice—in particular, the connection between scope of practice and access to health care—was a key issue on the agenda. Participants in the discussions about the issue noted that allowing health care practitioners who are not MDs or DOs to fully develop the potential of the scopes of practice available to them by their state practice acts better allows these health care practitioners to care for the growing number of insured. These licensed health care professionals offer quality health and wellness outcomes, cost-effective care, and necessary care for patients who might otherwise be forced to go without.

National Oversight Needed

The AMA advocates creating scope of practice committees on the state level to address these issues. CAC advocates forming a National Scope of Practice Advisory Board, to oversee the scopes of practice of individual health care professionals on a national level. Given that health professionals are regulated at the state level, it seems the CAC proposal would come up against a number of barriers to implementation. At both the state and national levels, AOTA and state occupational therapy associations are working to protect occupational therapy's scope of practice. At the state level, AOTA is watching for any state legislation that would create committees asserting control over scope-of-practice issues. At the national level, AOTA and CPR members are monitoring all efforts to create a national oversight body.

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Advocating With Insurance Commissioners To Define Key Terms

Marcy M. Buckner

Capital Briefing, OT Practice *Magazine, October 25, 2010*

The Patient Protection and Affordable Care Act (PPACA) was signed into law by President Barack Obama on March 23, 2010. PPACA requires that no later than 12 months after the date of enactment, the secretary of the U.S. Department of Health and Human Services (HHS) develop standards for use by group and individual health plans in compiling and providing to enrollees a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, PPACA requires the HHS secretary to consult with the National Association of Insurance Commissioners (NAIC), the organization of insurance regulators that works to develop uniform insurance policy.

In consultation with the secretary, NAIC by April had created a number of task forces, subgroups, and committees to develop resources and guidelines for future federal and state regulations that will be used to implement health care reform. To ensure that AOTA and its members had access to and influence over the products of these meetings, AOTA employed an outside consultant from Stateside Associates to monitor NAIC's PPACA-related meetings and provide weekly reports on NAIC's progress.

Specifying OT Services

In June, AOTA submitted comments to NAIC requesting that a technical correction be made to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act. The technical correction would add occupational therapy (OT) to the itemized lists of Medicare-covered services. Federal law and Medicare manual guidance specify that outpatient OT services are a benefit covered by Medicare. NAIC's model regulation, however, does not make this clear; it identifies *physical and speech therapy* by name as covered services but omits OT. An NAIC workgroup is still revising this model regulation, and AOTA is optimistic that OT will be listed as a Medicare-covered service in the final draft of the model regulation.

In July, AOTA submitted comments to the NAIC regarding definitions they were developing for *preferred provider* and *non-preferred provider*. At that time, NAIC defined these providers as "a licensed physician or other licensed health care professional or licensed facility." AOTA was concerned that the definitions did not provide for occupational therapists and/or occupational therapy assistants that practice in states that require only registration and not licensure. AOTA suggested that the language read that a provider is "a licensed physician or other health care professional who is licensed or otherwise regulated or licensed facility."

Defining a *Provider*

As of September, the NAIC Glossary of Health Insurance and Medical Terms defines a *provider* as "a physician (MD–Medical Doctor or DO–Doctor

Continued on page 6

Advocating With Insurance Commissioners To Define Key Terms

continued from page 5

of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law." AOTA is pleased that this definition will allow occupational therapists and occupational therapy assistants who practice in states without licensure laws to be recognized as health care professionals if registered as required by state law.

AOTA continues to monitor the NAIC as it develops definitions for *habilitation services* and *rehabilitation services*. The subgroup defines the terms as:

- Habilitation services: health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age.
- Rehabilitation services: health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Ongoing Advocacy

AOTA is pleased with the specific listing of OT in the definition of rehabilitation services and is advocating for the inclusion of OT in the definition of habilitation services. In September, AOTA submitted comments to NAIC regarding the definition of habilitation services. AOTA suggested that the language be amended to reflect the definition of rehabilitation services and to specifically mention OT. AOTA will continue to work with NAIC on the definition and mandated inclusion of habilitation services.

AOTA continues to monitor the progress of NAIC and its PPACA work groups. Stateside Associates' weekly NAIC reports may be viewed by AOTA members at www.aota.org/practitioners/advocacy/state/statenews/naic-reports.aspx.

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Note: *Since the publication of this article in the October 25 edition of* OT Practice, *AOTA successfully advocated for language to specifically mention occupational therapy in the definition of* habilitation *just as it is included in the definition of* rehabilitation.