RI Occupational Therapy Association

H5623-Opposed
March 30, 2025

Dear Chairperson Donovan and Members of the House Health and Human Services Committee,

Thank you for your service to Rhode Island.

My name is Janet Rivard Michaud. I am an Occupational Therapist of 38 years with 35 here in Rhode Island. I am writing today as the Advocacy Chair of the Rhode Island Occupational Therapy Association (RIOTA).

RIOTA is grateful for the opportunity to provide testimony on behalf of our membership in relation to House bill 5623.

H5623 attempts to address the growing challenges of Utilization Review for *"rehabilitative or habilitative services, including, but not limited to, physical therapy or occupational therapy services"*. Addressing the burdens of prior authorization and reauthorization procedures is an important and worthy focus to improve access to services for all Rhode Island health care consumers.

While included in this bill, Occupational Therapy was not incorporated into its drafting or consulted regarding its provisions or language and their impact on our professional services. On review of the bill, we note that it presents a number of concerns with potential negative effects on our clients and providers. **For ease of readability, please find these enumerated in relation to the pertinent sections of the bill in an appendix to this letter.**

For background:

- Occupational Therapy practitioners work with people of all ages, abilities and presentations to promote optimal levels of independence and satisfaction in everyday living.
- OT Practitioners work with individuals, groups, and populations.
- We address anything that interferes with function.
- These factors may be physical, emotional, psychological, cognitive, developmental, learning related, aging related, sociocultural and environmental barriers, and wellness concerns.
- We address the activities individuals do in their daily lives which have unique value, purpose and meaning for them from basic self-care to high level vocational demands and complicated group dynamics skills. These are termed occupations.
- Half of OT training is in psychosocial rehabilitation and the other half is in physical rehabilitation making us one of the truly holistic health care professions.

- Our role is to use task analysis to help people develop skills, rehabilitate skills impacted by illness, disease or injury, and adapt to new ways of doing things if needed.
- Occupational Therapy providers work in all settings, including but not limited to:

Early intervention	Independent living centers	Mental Health Facilities
Schools	Assisted living	Community Mental Health
Acute care hospitals	Skilled nursing facilities	Club House Settings
Acute rehab centers	Home Care	Senior Centers
Subacute Rehab	Group Homes	Community Centers
Outpatient Settings	Corporate Wellness Programs	Veterans Affairs Programs
Industry	Correctional Settings	Substance Use Programs

Sharing this overview of our field is to emphasize the breadth of areas where Occupational Therapy providers offer their services and what we must consider when reading a bill such as H5623 to assure that our clients are best served by it.

RIOTA believes the bill before you focuses primarily on an outpatient Physical Therapy private practice model. As such it does not appropriately cover the many settings where Occupational Therapy is provided or diagnostic groups of consumers which also would be affected by these insurance regulations.

RIOTA does not come comfortably into a position of opposition to bills whose intent was to improve access to care for RI consumers of rehabilitation services. We do, however, feel a strong professional responsibility to assure that such bills do not place any of our consumers or practitioners in a position of greater burden or risk through unintentional consequences.

We would welcome and have repeatedly requested the opportunity for dialogue and revisions related to the concerns presented in the appendix. However, for the bill as it stands, we must voice opposition.

After reviewing H5623, RIOTA would also suggest and support a simpler bill to eliminate prior authorization for all rehabilitative and habilitative services as a first step, perhaps something similar to Senator Ujifusa's bill S0053 that eliminates prior authorization for all services ordered by primary care providers. Such a bill would serve as a win-win situation for all involved. Applied to all three Rehabilitation professions, it would allow consumers seeking Occupational Therapy, Physical Therapy and Speech Therapy to begin services without the complication of prior authorization procedures and possible delays. On the insurers' side it would reduce overhead normally allocated for such procedures.

At this time RIOTA respectfully requests that H5623 as written not move forward from this committee for the concerns voiced above and in the appendix.

Thank you for your time and consideration.

Respectfully submitted,

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Appendix to RIOTA Testimony dated 3/30/2025 for House HHS Hearing on 4/1/25

General Concerns:

- **This bill includes Occupational Therapy but without OT participation in its drafting or any opportunity to provide input to language or provisions that on review present risks for consumers and providers. Of note, at a meeting with APTA RI on 2/7/25, RIOTA was asked to work with APTA RI on utilization review and enthusiastically agreed. RIOTA requested times to meet regarding this. There was no response prior to the introduction of this bill on 2/26/25 and no prior mention that it was being drafted placing our association in a difficult and time-limited situation to review and vet this bill.**
- **RIOTA has requested to meet and discuss this bill to work out something that all could support no less than 6 x without response or with comment that there is no receptivity to language changes.**
- **APTA RI has proposed removing Occupational Therapy from the bill language. This does not solve the issue: with language of "including but not limited to physical therapy and occupational therapy" this is a broad reaching bill affecting, OT, PT, speech and anyone providing rehabilitative or habilitative services. Even if the language "including but not limited to" were also removed, there is still the reality that insurance carriers tend to include OT, PT and Speech together in their policies and procedures. (see attachment from three major carriers demonstrating this). Whether Occupational Therapy is explicitly written into this bill or not, it is RIOTA's position that OT practice will still be affected.**
- **This bill is modeled on Maine legislation and our colleagues argue that this provides precedent. Respectfully Maine precedent is not Rhode Island's. The two states are very different with unique needs. Additionally, RIOTA has learned from our national reimbursement specialist that ME and WA are the two states in the US with the greatest burden of prior authorization demands so appear to stand in a category of their own.**
- **Most recently our physical therapy colleagues have framed this legislation as a stepping-stone style with intent to refine it or add to it in future sessions. Respectfully, this does not appear to be a realistic perspective. Once part of law, it seems that changes would be much more difficult to make particularly if they led to greater insurance carrier expenditures. And, potential negative impacts on portions of consumers and providers would already be in effect.**
  All three rehab Associations AOTA, APTA and ASHA have experienced this in collaborative advocacy efforts to correct the position of a single comma from federal regulations related to Medicare. The original document's error left OT with an

individual spending cap but PT and Speech with a combined one. All three associations have worked together for decades to correct this without success. The commonly accepted reason for this is that correcting the error would mean more financial expenditure.

- **Terminology throughout the bill is "prior authorization" without definition. Prior authorization is typically used for access to an initial appointment. Prior authorization for treatment has been used by Neighborhood Health Plan for approval of visits after initial allowed evaluation, and Reauthorization or authorization for additional visits is often used for more visits after the initial allowed. Clarifying terminology would be helpful to this bill to coincide with industry standards and to prevent loopholes in interpretation by carriers.**
- **RIOTA's perspective is that this bill is just not refined enough to move forward in its language and needs work on the provisions it includes in order to be the benefit it was intended to be.**

H5623 RIOTA wishes to share concerns identified in relation to specific bill language below.

The language in this bill is consistent for all sections below:
Section 1: Chapter 27-18 of the General Laws entitled "Accident and Sickness Insurance Policies"
2: Chapter 27-19 of the General Laws entitled "Nonprofit Hospital Service Corporations"
3: Chapter 27-20 of the General Laws entitled "Nonprofit Medical Service Corporations"
4: Chapter 27-41 of the General Laws entitled "Health Maintenance Organizations"
Please consider RIOTA's commentary relevant to all 4 sections.

3 27-18-95. Prior authorization for rehabilitative and habilitative services.

1) *(a) An individual or group health insurance plan shall not require prior authorization for rehabilitative or habilitative services, including, but not limited to, physical therapy or occupational therapy services for the first twelve (12) visits of each new episode of care*
This provision raised concerns particularly among our pediatric and hospital-based outpatient Occupational Therapy providers and some independent private practice clinicians.
    - **Prior authorization is not frequently required in these settings**
    - **Allowed number of visits are often much higher than 12 and often up to 20-30 visits are allowed per year with minimal or no reauthorization procedures**

Should this provision become law, more carriers may note an opportunity to reduce costs by changing their current more generous policies to 12 visits without prior authorization, adding further burden to providers and possible delays in care.

Whether OT is included or not in writing, this is a far-reaching bill and we anticipate that insurers will lump OT, PT and Speech together to avoid additional overhead in claims processing.

2) *For purposes of this section, "new episode of care" means treatment for a new or recurring condition for which an insured has not been treated by the provider within the previous ninety (90) days*
This definition of episode of care may work for many populations but does not provide for our hand, burn, multi-trauma and pediatric clients or complex medical clients who may have frequent need for medical/surgical interventions. In many settings, a new episode of care may be established after one of these events but for the same diagnosis and within the 90-day period. This presents the potential for a delay in resuming therapy in order to fulfill prior authorization procedures. This could negatively impact outcomes.

3) *After the twelve (12) visits of each new episode of care, an individual or group health insurance plan shall not require prior authorization more frequently than every six (6) visits or every thirty (30) days, whichever time period is longer*
This fits a straightforward orthopedic practice much of the time but not a more involved population. The number of visits specified is actually quite small for many complex client populations and such frequent reassessment has the potential to exacerbate symptoms slowing progress.

4) (b) *An individual or group health insurance plan shall not require prior authorization for physical medicine or rehabilitation services provided to patients with chronic pain for the first ninety (90) days following diagnosis in order to provide the necessary nonpharmacologic management of the pain.*
Provisions for individuals with chronic pain are well intended but again the language is challenging. To indicate treatment for 90 days "following diagnosis" leaves the vast majority of individuals with chronic pain out of this provision as it is rare that someone is referred immediately after diagnosis and many find their way to therapies only many years after being diagnosed though their need is significant.

Additionally, from an Occupational Therapy perspective this section should not only include those with chronic pain but those with chronic conditions where pain is not always present. For example, as currently written, an individual with ALS or another progressive neurological illness would potentially be subject to prior authorization or miss out on the guaranteed 90 days as opposed to someone with chronic neck or back pain. Some of our clients simply don't have the time to wait for care or reauthorization procedures.
Additionally, there is emerging ability to bill for outpatient Occupational Therapy for individuals with mental health diagnoses. It is not clear at this time what impact such regulations will have on this very vulnerable population.

5) *After the first ninety (90) days following a chronic pain diagnosis, an individual or group health insurance plan shall not require prior authorization more frequently than every six (6) visits or every thirty (30) days, whichever time period is longer.*
See comments in #3 above re number of visits.
Comment in #4 above also is relevant to the phrase "following a chronic pain diagnosis"
Additionally, reassessing and reauthorization every 6 visits for individuals in chronic pain or with chronic conditions is often exacerbating and not clinically productive

6) *(c) An individual or group health insurance plan shall respond to a prior authorization request for services or visits in an ongoing plan of care under this section within twenty-four (24) hours.*
This and the following guidelines for authorization time frames are again well intended and, in the best of all worlds, would be wonderful but are not realistic. A 24 hour turnaround time is highly unlikely except for truly emergent situations. More realistic is 48-72 hours to be fair to all parties.

7) *If an individual or group health insurance plan requires more information to make a decision on the prior authorization request, the individual or group health insurance plan shall notify the patient and the provider within twenty-four (24) hours of the initial request with the information that is needed to complete the prior authorization request including, but not limited to, the specific tests and measures needed from the patient and provider. An individual or group health insurance plan shall make a decision on the prior authorization request within twenty-four (24) hours of receiving the requested information.*
    - **Time frames again seem more ambitious than realistic.**
    - **RIOTA also has concerns re the language requiring carriers to indicate information needed to complete prior authorization** *"including but not limited to specific tests and measures needed from the patient and provider".*
      RIOTA believes this moves dangerously into the realm of clinical judgement. We are learning that many authorizations are being processed through algorithms and, if by humans, not necessarily clinicians. Concern among membership is that Artificial Intelligence may be being used more often as well, and there is worry about what this will be based on. As professionals, RIOTA supports the right of clinicians to determine how best to evaluate and reassess our clients. Having an insurance carrier determine specific tests and measures is not appropriate.
      Of course, dialogue re the results of our assessment is always welcome as part of educating and advocating for our clients.

In regard to the remainder of the sections, RIOTA supports the option for retroactive authorization and applauds its inclusion.
The usual appeal options and possibility of medical necessity review appear to fall into standard practice.

Thank you again for your consideration of these concerns and comments explaining RIOTA's objections to the unintended consequences of H5623.

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