MiOTA Newsletter

Michigan Occupational Therapy Association, Inc.

Winter 2011

Let's ROCK the Boat! – Don't be Left Out in the Cold with Healthcare Reform! by Kirsten Matthews

As you all are probably aware, big changes are underway; provided that healthcare reform isn't ruled as unconstitutional (the hearings on that are set for March with anticipated answers by June), healthcare as we know it is likely to take a drastic change in the next few years. MiOTA and its lobbying firm have been on the edge of their seats the past few months with lots of speculation of how various systems we as therapists and consumers will be impacted for the better and for the worse with the proposed changes. The first quarter of 2012 is expected to bring us the start of what could be our greatest challenges as a state association that we have had in years.

Our fall conference Committee couldn't have picked a better theme for this year's conference:

"Let's ROCK the Boat! – Don't be Left Out in the Cold!" (Health Care Reform)

Crossing the Straights of Mackinaw on the way to conference this year, there was certainly no avoiding being "rocked" this year. Not many of us had a perfectly smooth ride, most of us had a choppy ride, and a few of us even had bragging privileges to witnessing 12-14 foot waves! But, we braced for it, took a few deep breaths, strategically placed ourselves on the boat to avoid as much turbulence as we could, and we rode it out to a sunny, beautiful mainland and/or island (depending on which way you were heading).

On the ride that seemed to really take forever, I had a chance to do some thinking….

- What do we do when we are faced with the wind and waves of change?
- Do we get off the water and into safe harbor?
- Do we take into account all the variables, make our safety checks and proceed prepared but alert for danger – ready to take an alternative course of travel if the winds rock us too much?
- Do we just never bother to leave the mainland and turn a blind eye to the destination we wish to travel, abandoning our goal? Assuming someone on the mainland will just "take care of it" for us?

We at MiOTA work very hard to make sure you know how much we appreciate your membership and especially you promoting MiOTA, AOTA and just OT in general on a professional, consumer, and public policy level; we exist only because of you, after all! It is a membership organization.

When we say "it doesn't matter" or "I'm ONLY one person" or "What does MiOTA do for us" or my least favorite: "I had a membership, but I don't see what MiOTA every really did for me so I stopped my membership" in essence, we have stayed on the mainland. The reality is, your dues to MiOTA pay for our very proactive lobbyist – Muchmore Harrington Smalley and Associates (including the talents of Bret Marr and Cheryl Chapko) to watch our policies on a state level and to manage the MiOTA office. AOTA works on a federal/national level. However, MiOTA is your safeguard on the state level. When other disciplines put through bills that have language that encroaches on OT in Michigan – it is MiOTA that monitors and reacts. The auto no-fault bill? Medicaid policy changes? And now healthcare reform. As for myself and the other officers? We are all just volunteers, balancing families, careers and MiOTA to the best of our abilities; a task that comes easier some days than others.

- Who would watch out for OT in Michigan if MiOTA was not there?
- Would we be as strong without an unorganized voice?
- Would we be as strong without a lobbyist right in the capital talking to policy makers DIRECTLY about our opinions and concerns?

(Continued on page 2)

Let's ROCK the Boat! – Don't be Left Out in the Cold with Healthcare Reform! (Continued from page 1)

Sometimes we have no choice but to choose a safe harbor. Sometimes we have to be patient while politics get worked out, while rules get written before we can test the waters. But at least we are on the water armed and ready.

MiOTA is watching the wave heights, the wind speed, and the amount of fuel we have left so we can cross the straights of healthcare reform to our destination. We don't want to be left out in the cold, standing on the mainland when the budget cuts and healthcare policies come down on us. We are not going to stand by and let other professions take over our practice areas – the things we as OT's are best at just because we didn't "feel like" or didn't "think we" as one person were important enough to be noticed if we didn't renew that membership.

We are checking the waves – whether they are bills such as auto no-fault, the helmet law or just bills influencing our practice areas or Medicaid proposed policy changes or other healthcare reform. We are taking preparatory action for our safety and well-being. Thanks to Nancy Krolikowski's hard work, OT's will be able to bill BCBS in Michigan if they work in private practice. Thanks to Rob Ferguson and the licensure committee's efforts, we are now a licensed profession.

And we are proceeding across this tricky and turbulent time – across the open water, waves splashing 20 feet tall and trying to intimidate us to go back to our homes, to stay off the lake, but we are not going out without a fight, because we know the value of the services we provide and we have a responsibility to our current and our future generations of OT's and consumers to protect what we are best at and take responsibility for our future.

Thank you for all that you do to secure our boat and help us to navigate these tough waters or budgets and reform.

A special thank you to the MiOTA Fall Conference Exhibitors!

Platinum Sponsors

HCR ManorCare
Michigan Health & Rehabilitations Services
Home Rehabilitation Services of Michigan

Bronze Sponsors

Muchmore Harrington
Smalley & Associates
Genesis Rehab Services

Exhibitors

HCR ManorCare
Borgess Health
Ambucs
ENCORE! Rehabilitation Services
Detroit Medical Center
Siesta Silver Jewelry
Michigan Health and Rehabilitation Services & Home Rehabilitation Services of Michigan
University of Michigan Brachial Plexus Program
ProStep Rehab (Rehab Division of Extendicare)
American Occupational Therapy Association
H. Alan Dahl & Associates
US Army Health Care
School Specialty
Rehab Without Walls
Mary Free Bed Rehab Hospital
CREFORM Corporation
Agility Health
University of Indianapolis, School of Occupational Therapy
Double Dip Creations
Life Care Centers of America
Advantage Mobility Outfitters

MiOTA Membership Report by Cathleen Johnson

A variety of new incentives to increase continuity of membership and newly created memberships were implemented during this past year. Additionally, a focus on facilitating student membership was implemented to develop strong professional involvement early in the OT practitioner career.
On August 8, 2011, renewal notices were emailed to 99 members whose memberships had an expiration date of March 1 – August 31, 2011. A second notice was sent August 30, 2011. Twenty-six (26) renewed their membership; and the other 73 were marked Inactive in the database.
New memberships with conference registration are:

OT:	19	OTA:	2
Student:	6	Renewals	3

Membership by the Numbers As of October 11, 2011

Associate Member:	2
Honorary Member	8
OT Member	255
OTA Member	33
Retired Member	19
Student Member	101
Total:	518

Membership Incentives initiated during past year

New Recruitment Incentive

- MiOTA encouraged members to recruit new members. The incentive was for an existing member to recruit a new member**.**
- Friends and Colleagues Plan:
    - Refer a friend or colleague who is not a current member and get $10.00 off your membership as you renew.
    - Two new members join together ; each receive $10.00 off their first year of membership
    - Get one year of free membership by referring 5 new members

Multi – Year Discount

- **MiOTA encouraged membership to renew membership for multiple years – currently 1 year is at a cost of $89.00 however if a member renews for 2 or 3 years the cost is reduced significantly.**
- Multi – year Discount
    - 1 year = $89.00
    - 2 years =$158.00 ($79.00/year)
    - 3 years = 225.00 ($75.00/year)
- Student Participation Contest

Students from Baker College of Allen Park, Baker College of Muskegon, Macomb Community College, Saginaw Valley State University and Western Michigan University were represented as registered participants. The school with the greatest percentage of student registered in relation to their overall # of students enrolled is recognized at our 2011 conference & received on free student registration as well as a ribbon on their name badge.
Congratulations Baker College of Muskegon!!!

Communications Report by Nancy Milligan

Website

- The purpose of the MiOTA Website is to provide a communication vehicle and resource for information of importance to the citizens, customers, OT practitioners and OT/OTA students in the state of Michigan.
- Our goal for 2010/11 was to update the association website to make it more user friendly and have the current information readily available for our membership.
- With the help of a paid website developer, Pat Vander Lee, we are well on our way.
- Claudette Reid continues to serve as the website coordinator. If you would like to advertise or have something posted on the website please forward the information to Cheryl Chapko through the MiOTA office for approval.
- If you have any suggestions to help us to improve the website please forward your suggestions to Claudette Reid at claudot@chartermi.net .

Listserv

- The purpose of the MiOTA Listserv is to provide a forum for member-to-member communication on clinical, policy and research issues relevant to the practice of OT in the state of Michigan.
- We continue to use the free service available through yahoo groups as our current list serve provider.
- Our plan is to roll over to another list serve that will provide our members a more reliable service.
- We are currently researching possible list serve providers and roll over our members to a new list serve.
- Thank you to Sandy Thom for her years of service keeping our members connected to one another!!!

Newsletter

- The purpose of the MiOTA Newsletter is to provide a regular update to all members on issues and information pertinent to the practice of OT in the state.
- Donna Case continues to serve as our Newsletter Coordinator. Many of our members have opted to now receive their quarterly newsletter by email. If you would like to have your subscription sent to you by email please let Cheryl Chapko know.

Network Coordinator-

- The role of the Networking Coordinator is to support and coordinate the activities of the grass-roots member groups within MiOTA that are structured around either geographic and practice areas. The position is currently vacant

Please email the MiOTA office if you are interested in volunteering: office@miota.org

Chapters

Detroit: Pam Pearson /Melissa Libra
Huron Valley: Lynette Rasmussen
Northern (Traverse City): Vacant
Saginaw Valley: Jean Prast
Upper Peninsula: Mary Jo Vaughn
Lansing: Vacant
Western: Vacant
Southwest: Vacant

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Special Interest Sections (SIS)

Admin. & Management: Kim Murphy
Education: Joanne Crain
Hands: Laurie Saunders
Home Health: Laura Woodworth
Peds & SI: Kirsten Matthews
Work: William Sisco

MiOTA Awards Given at Fall Conference

Certificate of Appreciation

- To express the appreciation of MiOTA to members and non-members for extraordinary contributions to the advancement of OT.

Rasa Poorman & the Hand Therapy SIS

Departmental Membership Award

To actively support MiOTA participation by recognizing occupational therapy departments in which 80% or more of the staff are members of MiOTA

Bell Hospital Outpatient Occupational Therapy
Deb McCoy
Rich Matthews
Joanna Nicholas
Kirsten Matthews
(80% Membership)

Distinguished Service Awards

- To honor members of MiOTA for extraordinary service to MiOTA. Nominees have made continuing and outstanding contributions to the development, growth and process of MiOTA.

Awarded to:
Angie Bayci
Mary Ellen East
Howard Achtman
Nancy Lakin
Cathleen Johnson
Denise Justice

Master Clinician Award

- To recognize members of MiOTA, who with their knowledge and expertise, have made a significant contribution to occupational therapy through a combination of some of the following: supervision of students and staff; articles and presentations; workshops; mentoring; education; therapeutic work with clients and families. This therapist stands head and shoulders above the crowd: a model for fellow therapists.

Awarded to: Doug Rakowski

OT Award of Excellence

- To honor members of MiOTA who have made an outstanding global contribution to the profession.

Awarded to: Jessica Hunt
Carole Dodge

OT Honorary Member Award

- To recognize MiOTA members who have, or are, retiring, and who have performed distinguished service in the field of occupational therapy.
- Honorary members receive a free, life membership in MiOTA.

Awarded to: Fred Sammons

Fellow of the Michigan Occupational Therapy Association

- To recognize members of MiOTA who, with their knowledge and expertise, during their career have made a significant contribution to the continuing education and professional development of members.
- Will be allowed to use credentials - FMiOTA

Awarded to: Gerry Conti
Janet Negada
Nancy Milligan

MEMBERS QUESTIONS

"Can an OTA do a progress note co-signed by the OT for Medicare (and it be reimbursed)?

Right now, the recommendation in our facility is that any objective data the OTA collects should go into a daily note, and the OTR puts in into the progress note. There is confusion on if the OTA can put that information into the progress note and then the OT come along and do the interpretation and finish the note and sign it. Michigan licensure allows OTA's to participate in progress notes if they are not the sole evaluator, but the question is, in an outpatient setting, does Medicare allow it? We've been told that OTA's they cannot write; they can take measurements, provide data, insight and discussion but legally cannot write the note." In other words, they do all progress note type activities in a daily note."

Chuck Willmarth, Director, State Affairs and Reimbursement & Regulatory Policy with AOTA was kind enough to assist us in finding the answer you see below to the question. Please see the cut and pasted sections from the Medicare Benefit Policy Manual regarding the Progress Report and the Treatment Note. Both sections include information about the role of assistants. This section applies to OT and PT. In addition, the highlighted section below includes a section about assistants and progress reports. Chuck has also included the section on the treatment note that also addresses assistants.

Sections below taken from Chapter 15, Medicare Benefit Policy Manual

https://www.cms.gov/manuals/Downloads/bp102c15.pdf (page 180)

D. Progress Report

The Progress Report provides justification for the medical necessity of treatment.

Contractors shall determine the necessity of services based on the delivery of services as directed in the plan and as documented in the Treatment Notes and Progress Report. For Medicare payment purposes, information required in Progress Reports shall be written by a clinician that is, either the physician/NPP who provides or supervises the services, or by the therapist who provides the services and supervises an assistant. It is not required that the referring or supervising physician/NPP sign the Progress Reports written by a PT, OT or SLP.

Timing. The minimum Progress Report Period shall be at least once every 10 treatment days or at least once during each 30 calendar days, whichever is less. The day beginning the first reporting period is the first day of the episode of treatment regardless of whether the service provided on that day is an evaluation, re-evaluation or treatment. Regardless of the date on which the report is actually written (and dated), the end of the Progress Report Period is either a date chosen by the clinician, the 10th treatment day, or the 30th calendar day of the episode of treatment, whichever is shorter. The next treatment day begins the next reporting period. The Progress Report Period requirements are complete when both the elements of the Progress Report and the clinician's active participation in treatment have been documented. For example, for a patient evaluated on Monday, October 1 and being treated five times a week, on weekdays: On October 5, (before it is required), the clinician may choose to write a Progress Report for the last week's treatment (from October 1 to October 5). October 5 ends the reporting period and the next treatment on Monday, October 8 begins the next reporting period. If the clinician does not choose to write a report for the next week, the next report is required to cover October 8 through October 19, which would be 10 treatment days.

It should be emphasized that the dates for recertification of plans of care do not affect the dates for required Progress Reports. (Consideration of the case in preparation for a report may lead the therapist to request early recertification. However, each report does not require recertification of the plan, and there may be several reports between recertifications). In many settings, weekly Progress Reports are voluntarily prepared to review progress, describe the skilled treatment, update goals, and inform physician/NPPs or other staff. The clinical judgment demonstrated in frequent reports may help justify that the skills of a therapist are being applied, and that services are medically necessary. Particularly where the patient's medical status, or appropriate tapering of frequency due to expected progress towards goals, results in limited frequency e.g., (2-4 times a month), more frequent Progress Reports can differentiate rehabilitative from maintenance treatment, document progress and justify the continued necessity for skilled care.

Absences. Holidays, sick days or other patient absences may fall within the Progress Report Period. Days on which a patient does not encounter qualified professional or qualified personnel for treatment, evaluation or re-evaluation do not count as treatment days. However, absences do not affect the requirement for a Progress Report at least once during each Progress Report Period. If the patient is absent unexpectedly at the end of the reporting period, when the clinician has not yet provided the required active participation during that reporting period, a Progress Report is still required, but without the clinician's active participation in treatment, the requirements of the Progress Report Period are incomplete.

Delayed Reports. If the clinician has not written a Progress Report before the end of the Progress Reporting Period, it shall be written within 7calendar days after the end of the reporting period. If the clinician did not participate actively in treatment during the Progress

Member Question Continued from Page 6

Report Period, documentation of the delayed active participation shall be entered in the Treatment Note as soon as possible. The Treatment Note shall explain the reason for the clinician's missed active participation. Also, the Treatment Note shall document the clinician's guidance to the assistant or qualified personnel to justify that the skills of a therapist were required during the reporting period. It is not necessary to include in this Treatment Note any information already recorded in prior Treatment Notes or Progress Reports.

The contractor shall make a clinical judgment whether continued treatment by assistants or qualified personnel is reasonable and necessary when the clinician has not actively participated in treatment for longer than one reporting period. Judgment shall be based on the individual case and documentation of the application of the clinician's skills to guide the assistant or qualified personnel during and after the reporting period.

Early Reports. Often, Progress Reports are written weekly, or even daily, at the discretion of the clinician. Clinicians are encouraged, but not required to write Progress Reports more frequently than the minimum required in order to allow anyone who reviews the records to easily determine that the services provided are appropriate, covered and payable.

Elements of Progress Reports may be written in the Treatment Notes if the provider/supplier or clinician prefers. If each element required in a Progress Report is included in the Treatment Notes at least once during the Progress Report Period, then a separate Progress Report is not required. Also, elements of the Progress Report may be incorporated into a revised Plan of Care when one is indicated. Although the Progress Report written by a therapist does not require a physician/NPP signature when written as a stand-alone document, the revised Plan of Care accompanied by the Progress Report shall be re-certified by a physician/NPP. See the section 220.1.2C on Plan of Care for guidance on when a revised plan requires certification.

Progress Reports for Services Billed Incident to a Physician's Service. The policy for incident to services requires, for example, the physician's initial service, direct supervision of therapy services, and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment (See section 60.1B of this chapter. Also, see the billing requirements for services incident to a physician in Pub. 100-04, chapter 26, Items 17, 19, 24, and 31.) Therefore, supervision and reporting requirements for supervising physician/NPPs supervising staff are the same as those for PTs and OTs supervising PTAs and OTAs with certain exceptions noted below.

When a therapy service is provided by a therapist, supervised by a physician/NPP and billed incident to the services of the physician/NPP, the Progress Report shall be written and signed by the therapist who provides the services. When the services incident to a physician are provided by qualified personnel who are not therapists, the ordering or supervising physician/NPP must personally provide at least one treatment session during each Progress Report Period and sign the Progress Report.

Documenting Clinician Participation in Treatment in the Progress Report. Verification of the clinician's required participation in treatment during the Progress Report Period shall be documented by the clinician's signature on the Treatment Note and/or on the Progress Report. When unexpected discontinuation of treatment occurs, contractors shall not require a clinician's participation in treatment for the incomplete reporting period.

The Discharge Note (or Discharge Summary) is required for each episode of outpatient treatment. In provider settings where the physician/NPP writes a discharge summary and the discharge documentation meets the requirements of the provider setting, a separate discharge note written by a therapist is not required. The Discharge Note shall be a Progress Report written by a clinician, and shall cover the reporting period from the last Progress Report to the date of discharge. In the case of a discharge unanticipated in the plan or previous Progress Report, the clinician may base any judgments required to write the report on the Treatment Notes and verbal reports of the assistant or qualified personnel.

In the case of a discharge anticipated within 3 treatment days of the Progress Report, the clinician may provide objective goals which, when met, will authorize the assistant or qualified personnel to discharge the patient. In that case, the clinician should verify that the services provided prior to discharge continued to require the skills of a therapist, and services were provided or supervised by a clinician. The Discharge Note shall include all treatment provided since the last Progress Report and indicate that the therapist reviewed the notes and agrees to the discharge. At the discretion of the clinician, the discharge note may include additional information; for example, it may summarize the entire episode of treatment, or justify services that may have extended beyond those usually expected for the patient's condition. Clinicians should consider the discharge note the last opportunity to justify the medical necessity of the entire treatment episode in case the record is reviewed. The record should be reviewed and organized so that the required documentation is ready for presentation to the contractor if requested.

Assistant's Participation in the Progress Report

Physical Therapist Assistants or Occupational Therapy Assistants may write elements of the Progress Report dated between clinician reports. Reports written by assistants are not complete Progress Reports. The clinician must write a Progress Report during each Progress Report Period regardless of whether the assistant writes other reports. However, reports written by assistants are part of the record and need not be copied into the clinicians report. Progress Reports written by assistants supplement the reports of clinicians and shall include:

Member Question Continued from Page 7

• Date of the beginning and end of the reporting period that this report refers to;

• Date that the report was written (not required to be within the reporting period);

• Signature, and professional identification, or for dictated documentation, the identification of the qualified professional who wrote the report and the date on which it was dictated;

• Objective reports of the patient's subjective statements, if they are relevant. For example, "Patient reports pain after 20 repetitions". Or, "The patient was not feeling well on 11/05/06 and refused to complete the treatment session."; and

• Objective measurements (preferred) or description of changes in status relative to each goal currently being addressed in treatment, if they occur. Note that assistants may not make clinical judgments about why progress was or was not made, but may report the progress objectively. For example: "increasing strength" is not an objective measurement, but "patient ambulates 15 feet with maximum assistance" is objective.

Descriptions shall make identifiable reference to the goals in the current plan of care. Since only long term goals are required in the plan of care, the Progress Report may be used to add, change or delete short term goals. Assistants may change goals only under the direction of a clinician. When short term goal changes are dictated to an assistant or to qualified personnel, report the change, clinician's name, and date. Clinicians verify these changes by cosignatures on the report or in the clinician's Progress Report. (See section 220.1.2(C) to modify the plan for changes in long term goals). The evaluation and plan of care are considered incorporated into the Progress Report, and information in them is not required to be repeated in the report. For example, if a time interval for the treatment is not specifically stated, it is assumed that the goals refer to the plan of care active for the current Progress Report Period. If a body part is not specifically noted, it is assumed the treatment is consistent with the evaluation and plan of care.Any consistent method of identifying the goals may be used. Preferably, the long term goals may be numbered (1, 2, 3,) and the short term goals that relate to the long term goals may be numbered and lettered 1.A, 1.B, etc. The identifier of a goal on the plan of care may not be changed during the episode of care to which the plan refers. A clinician, an assistant on the order of a therapist or qualified personnel on the order of a physician/NPP shall add new goals with new identifiers or letters. Omit reference to a goal after a clinician has reported it to be met, and that clinician's signature verifies the change.

Content of Clinician (Therapist, Physician/NPP) Progress Reports. In addition to the requirements above for notes written by assistants, the Progress Report of a clinician shall also include:

• Assessment of improvement, extent of progress (or lack thereof) toward each goal;

• Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions should be documented in the clinician's Progress Report; and

• Changes to long or short term goals, discharge or an updated plan of care that is sent to the physician/NPP for certification of the next interval of treatment.

A re-evaluation should not be required before every Progress Report routinely, but may be appropriate when assessment suggests changes not anticipated in the original plan of care. Care must be taken to assure that documentation justifies the necessity of the services provided during the reporting period, particularly when reports are written at the minimum frequency. Justification for treatment must include, for example, objective evidence or a clinically supportable statement of expectation that:

• The patient's condition has the potential to improve or is improving in response to therapy;
• Maximum improvement is yet to be attained; and
• There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

Objective evidence consists of standardized patient assessment instruments, outcome measurements tools or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during and/or after treatment is recommended to quantify progress and support justifications for continued treatment. Such tools are not required, but their use will enhance the justification for needed therapy. Example: The Plan states diagnosis is 787.2- Dysphagia secondary to other late effects of CVA. Patient is on a restricted diet and wants to drink thick liquids. Therapy is planned 3X week, 45 minute sessions for 6 weeks. Long term goal is to consume a mechanical soft diet with thin liquids without complications such as aspiration pneumonia. Short Term Goal 1: Patient will improve rate of laryngeal elevation/timing of closure by using the super-supraglottic swallow on saliva swallows without cues on 90% of trials. Goal 2: Patient will compensate for reduced laryngeal elevation by controlling bolus size to ½ teaspoon without cues 100%. The Progress Report for 1/3/06 to 1/29/06 states: 1. Improved to 80% of trials; 2. Achieved. Comments: Highly motivated; spouse assists with practicing, compliant with current restrictions. New Goal: "5. Patient will implement above strategies to swallow a sip of water without coughing for 5 consecutive trials. Mary Johns, CCC-SLP, 1/29/06." Note the provider is billing 92526 three times a week, consistent with the plan; progress is documented; skilled treatment is documented.

E. Treatment Note

The purpose of these notes is simply to create a record of all treatments and skilled interventions that are provided and to record the time of the services in order to justify the use of billing codes on the claim. Documentation is required for every treatment day, and every therapy service. The format shall not be dictated by contractors and may vary depending on the practice of the responsible clinician and/or the clinical setting

Member Question Continued from Page 8

The Treatment Note is not required to document the medical necessity or appropriateness of the ongoing therapy services. Descriptions of skilled interventions should be included in the plan or the Progress Reports and are allowed, but not required daily. Non-skilled interventions need not be recorded in the Treatment Notes as they are not billable. However, notation of non-skilled treatment or report of activities performed by the patient or non-skilled staff may be reported voluntarily as additional information if they are relevant and not billed. Specifics such as number of repetitions of an exercise and other details included in the plan of care need not be repeated in the Treatment Notes unless they are changed from the plan.

Documentation of each Treatment shall include the following required elements:

• Date of treatment; and
• Identification of each specific intervention/modality provided and billed, for both timed and untimed codes, in language that can be compared with the billing on the claim to verify correct coding. Record each service provided that is represented by a timed code, regardless of whether or not it is billed, because the unbilled timed services may impact the billing; and
• Total timed code treatment minutes and total treatment time in minutes. Total treatment time includes the minutes for timed code treatment and untimed code treatment. Total treatment time does not include time for services that are not billable (e.g., rest periods). For Medicare purposes, it is not required that unbilled services that are not part of the total treatment minutes be recorded, although they may be included voluntarily to provide an accurate description of the treatment, show consistency with the plan, or comply with state or local policies. The amount of time for each specific intervention/modality provided to the patient may also be recorded voluntarily, but contractors shall not require it, as it is indicated in the billing. The billing and the total timed code treatment minutes must be consistent. See Pub. 100-04, chapter 5, section 20.2 for description of billing timed codes; and
• Signature and professional identification of the qualified professional who furnished or supervised the services and a list of each person who contributed to that treatment (i.e., the signature of Kathleen Smith, PTA, with notation of phone consultation with Judy Jones, PT, supervisor, when permitted by state and local law). The signature and identification of the supervisor need not be on each Treatment Note, unless the supervisor actively participated in the treatment. Since a clinician must be identified on the Plan of Care and the Progress Report, the name and professional identification of the supervisor responsible for the treatment is assumed to be the clinician who wrote the plan or report. When the treatment is supervised without active participation by the supervisor, the supervisor is not required to cosign the Treatment Note written by a qualified professional. When the responsible supervisor is absent, the presence of a similarly qualified supervisor on the clinic roster for that day is sufficient documentation and it is not required that the substitute supervisor sign or be identified in the documentation. If a treatment is added or changed under the direction of a clinician during the treatment days between the Progress Reports, the change must be recorded and justified on the medical record, either in the Treatment Note or the Progress Report, as determined by the policies of the provider/supplier. New exercises added or changes made to the exercise program help justify that the services are skilled. For example: The original plan was for therapeutic activities, gait training and neuromuscular re-education. “On Feb. 1 clinician added electrical stim. to address shoulder pain.”

Documentation of each treatment may also include the following optional elements to be mentioned only if the qualified professional recording the note determines they are appropriate and relevant. If these are not recorded daily, any relevant information should be included in the progress report.

- Patient self-report;
- Adverse reaction to intervention;
- Communication/consultation with other providers (e.g., supervising clinician, attending physician, nurse, another therapist, etc.);
- Significant, unusual or unexpected changes in clinical status;
- Equipment provided; and/or
- Any additional relevant information the qualified professional finds appropriate.

See Pub. 100-04, chapter 5, section 20.2 for instructions on how to count minutes. It is important that the total number of timed treatment minutes support the billing of units on the claim, and that the total treatment time reflects services billed as untimed codes.

A special thank you to Chuck Willmarth and Sue Robosan-Burt for their assistance in answering this member question! In addition to Chuck’s response above, Sue provided the groundwork knowledge that shaped the question you see above for what is acceptable according to Michigan OT Licensure.

AOTA NEEDS YOUR HELP! Call for Bylaws Amendments

The Bylaws, Policies, and Procedures Committee (BPPC) is asking all interested AOTA members to review the current Bylaws and send proposed changes by **December 9, 2011** to ra@aota.org. Amendments/revisions will be reviewed and prepared by BPPC in January 2012 and sent to the Board of Directors for input. The draft 2012 Bylaws will then be posted on the AOTA Web site (www.aota.org) for review by the membership prior to consideration at the 2012 Representative Assembly (RA) and the Annual Business Meeting at AOTA’s annual conference in Indianapolis. A copy of the current Bylaws is posted on the AOTA Web site at http://www.aota.org/Governance.aspx *Get Involved!> Reference Documents*. If you would like to receive an electronic version of the Bylaws to review, please e-mail Debbie Hippchen at ra@aota.org. All proposed revisions should be made using the track changes feature in Microsoft Word. The BPPC encourages your member participation in the Bylaws review process and is available to answer any questions or concerns at the above e-mail.

Independent Occupational Therapists and Blue Cross Blue Shield of Michigan by

Nancy Krolikowski, MS, OTRL, CHT MiOTA BCBSM Liaison

Independent Occupational Therapist (IOT) has been added as a provider group for Blue Cross Blue Shield of Michigan (BCBSM), effective January 1, 2012. To be considered, the occupational therapist must:

- Have an NPI number through Medicare
- Have a Medicare number as a private practice occupational therapist
- Have an active occupational therapy license for the state of Michigan
- Maintain professional liability insurance as defined by BCBSM, covering the therapist regardless of the location of service

To apply, go to bcbsm.com. The application is found under Enrollment and Changes in the Provider section.

If you are working as an employee of an Outpatient Rehabilitation Facility, the facility is a provider for BCBSM (you are an employee and not an IOT). You don't need to complete any additional paperwork since the IOT status does not apply in this situation.

If you are employed in an Independent Physical Therapist practice, you MUST enroll as an IOT. Your services cannot be billed without your individual BCBSM provider number as an IOT. Even though the company is identified as an IPT, in this situation, you would enroll as an IOT and have your payments assigned to the corporation that employs you.

If you are an employee of a physician, you are working incident to the physician. Billing goes through the physician's provider number. The physician is supervising your services. You don't need to complete any additional paperwork. The incident to policies/procedures remain; refer to WEBDENIS for these policies/procedures.

WEBDENIS also provides some direction on documentation procedures to follow. I have been in contact with BCBSM and we are trying to put together a training session on documentation guidelines. Please email me at NancyKroOT@msn.com if you would be interested in attending a documentation training session. As always, it's not a bad idea to also follow Medicare documentation guidelines. Note to all IOT: please be thorough; if it's not recorded, consider that it didn't happen.

Please continue to contact me regarding BCBSM. Good stories and bad stories are welcomed (why do we forget to share the good stories?).

Many thanks to BCBSM and their dedicated staff on making 2012 a great year. I wish all of you a happy and prosperous New Year.

Detroit/ Huron Valley Chapter Meeting
March 3rd 2012 9:30 to 12 noon at
Creform Corporation
49037 Wixom Tech Dr.
Wixom MI 48393

Participants will be able to have hands-on opportunity with the materials.

2012
Michigan Occupational Therapy Association
Annual Fall Conference

Radisson Plaza Hotel
100 W Michigan Ave
Kalamazoo, MI 49007

Call for Papers Cover Sheet
Deadline: March 1, 2012

Presenter's Name_____Credentials_____
(Primary contact – confirmation letter will be sent to this person)

Company/Facility: _____

Email _____ Fax#_____

Address _____

City_____ State _____ Zip_____

Day Phone # _____ Evening Phone # _____

Title of Presentation_____

Proposals should reflect current issues, trends, and best practice.

We are also looking for presentations on *Documentation, Ethics, and Pain Control Measures.*

Hand SIS Winter 2012 by *Lydia Christesen OTD,OTR,CHT*

Oswald Chambers once said "We tend to lose our enthusiasm when there is no vision, no uplift just the common round, the trivial task." As we enter into the long winter months let us take to heart what Oswald Chambers said and work with a vision. Let us look introspectively and determine what we could do better and then visualize the steps we need to bring about our success. (Isn't this what we frequently try and teach our patients?) With that thought in mind have any of you wanted to improve your mobilization skills? If the answer is yes there will be a conference June 1 and 2nd on Joint Mobilization of the Upper Extremity in Frankenmuth. The Hand SIS group is excited to bring Ken Flowers and Paul LaStayo to Michigan to teach us or reteach us joint mobilization. Included in this newsletter is the registration form and tentative agenda for the conference. Please consider the conference as you are developing of your vision for the year.

2012 MiOTA Call for Papers - Proposal for Presentation
Deadline March 1, 2012

Presentation Title_____

Audio Visual Equipment Needs

Please request only items that are necessary for your presentation. Equipment not listed below is unavailable so you will need to bring those items yourself.

☐ **LCD Projector ***
☐ **DVD player**
☐ **VCR**
(Please bring your own computer)

Room set up will be Theatre Style, unless otherwise specified below.

Amount of time needed:
☐ **1 hour** ☐ **2 hours** ☐ **3 hours ***

Presentation Type:
☐ **Workshop** ☐ **Institute *** ☐ **Poster** ☐ **Panel**
*** These sessions will be considered for Pre Conference ***

Level of Presentation Content: **(check all that apply)**
☐ **OT Student** ☐ **Entry** ☐ **Intermediate** ☐ **Advanced**

Presentation Category: **(check all that apply)**

☐ **Education**	☐ **General**	☐ **Pediatrics**	☐ **Work**
☐ **Psychosocial**	☐ **Research**	☐ **School-based**	☐ **Sensory Integration**
☐ **Physical Disabilities**	☐ **Student Presentation**	☐ **Student Research Project**	☐ **SIS Meeting**

☐ **Home Health** **Hands** **Other (please specify)**

2012 MiOTA Call for Papers - Proposal for Presentation
Deadline March 1, 2012

Presentation Title: _____

List names of Presenter(s) exactly as you want them to appear in the program:
Biographical overview, name, credentials….

Presenter 1

Presenter 2

Presenter 3

Presenter 4

Requirements for submitting your 2012 MiOTA Call for Papers

Your Proposal for Presentation at the 2012 MiOTA Conference MUST include the following:

1. **Cover Sheet with primary contact person's name, address, phone, fax and email address. (1st page of this Call for Papers document)**
2. **Formal Abstract: Provide a brief summary that clearly states the title, purpose and content of the presentation, its relevance to OT and specific learning objectives. (Double-spaced, Maximum 150 words)**
3. **A brief (1/4 page or less) biographical overview for <u>each</u> speaker. This will be used for the introduction of your presentation at conference.**

Deadline for responding to the Call for Papers is March 1, 2012

Please Mail, Fax or E-Mail all 3 parts of your presentation proposal for the 2012 MiOTA Fall Conference to:

Cheryl Chapko MiOTA Office	**Fax: 517-484-4442** **E-Mail: <u>office@miota.org</u>**

MI Chapter of ASHT/MiOTA Hand SIS
Presents

Joint Mobilizations for the Upper Extremity
By Ken Flowers, PT, CHT and Paul LaStayo, PT, PhD, CHT

Date: Friday, June 1- Saturday, June 2, 2012
Time: Friday 7:30 am – 5:00 pm and Saturday 7:30-12:00noon
Location: Frankenmuth Bavarian Inn Restaurant, Frankenmuth, Mi
713 S. Main Street Frankenmuth, MI 48734 Phone: (989) 652-9941 or 1-800-BAVARIA

Cost: MiOTA / MPTA /ASHT Member/ Students: $225
Nonmembers: $250
Late Registration (AFTER May 12): $250 /$275
LIMITED TO 50 ATTENDEES

For any Questions, please call Rasa Poorman, OTR/L, CHT at (248) 543-4886
Make checks payable to **Michigan Chapter of ASHT** and mail to:
Rasa Poorman OTR, CHT 25529 Keenan Ct., Novi, MI 48375
Confirmations will be emailed

For lodging arrangements please contact the Frankenmuth Fairfield Inn @ 989-652-5000 (430 South Main Street-Frankenmuth, MI 48734). A block of rooms is being held at a discounted rate of $74.00 for Thursday evening and $116.00 for Friday evening. The hotel is walking distance to the conference center. The room block/ discounted rates expires on April, 31, 2012. To receive the discounted rate, mention the ASHT Conference.

Registration Form (please complete ENTIRE form-CLEARLY)
Confirmations will be **E-MAILED**

Name _____

Address:_____

Employer:_____

Phone: _____

E-mail_____

Are you and MiOTA / MPTA or ASHT member ? Yes / No

Membership #_____

Total amount enclosed:_____

MI Chapter of ASHT/MiOTA Hand SIS
Presents

Joint Mobilizations for the Upper Extremity
By Ken Flowers, PT, CHT and Paul LaStayo, PT, PhD, CHT

TENTATIVE AGENDA

Friday June 1

7:30 – 8:00	Registration, continental breakfast
8:00 -9:00	Introduction to mobilization
9:00 – 10:00	History and theory of manual therapy
10:00 – 10:15	Vendor break
10:15 – 12:00	Hand Anatomy/Hand Mobilization Lab
12:00 – 1:00	Lunch (included)
1:00 – 2:00	Shoulder Anatomy
2:00 – 3:00	Shoulder mob lab
3:00 – 3:15	Vendor break
3:15 - 4:30	Shoulder lab cont
4:30 – 5:00	Questions

Saturday June 2

7:30 – 8:00	Breakfast
8:00 – 9:00	Wrist Anatomy
9:00 – 10:00	Wrist mob lab
10:00 – 10:15	Break
10;15 – 11:00	Hierarchy of Splinting
11:00 – 12:00	Elbow to end

News from MiOTA Lobbyists by Bret Marr Muchmore Harrington Smalley & Associates

Three topics: auto no fault, BCBSM reform, health exchange and ACA implementation. I'm always open to additions/deletions or other comments as you guys see fit.

In November of 2010, voters in Michigan made the decisive choice to give a never before elected businessman the reins of state government. Rick Snyder wasted no time in his efforts to reform Michigan. His budget earlier this year was adopted by the legislature earlier than any other state budget in the past decade. He promised business tax relief and proposed a plan that was adopted quickly by his legislative supporters. He began an all encompassing process of evaluating every detail of state government and shedding those functions that weren't essential in his view. All of these changes took place in the first half of 2011.

The last half of 2011 has seen a number of proposal being put forth that impact all health care providers. The fall session started off with a legislative proposal, HB 4936 (Lund), that sought to radically change the auto no-fault insurance landscape in Michigan. The proposal would implement a fee schedule based on the workers compensation system. This fee schedule is seldomly utilized by health care professional and pays a rate far below commercial health insurance and Medicaid rates. The bill was reported from committee after 15 hours of testimony in opposition from health care providers across the state. MIOTA submitted testimony in opposition to the proposal and lobbied members of the House to express their opposition to the proposal. Since reporting the bill from committee, House leaders sought to change the bill to generate the necessary votes for passage. With health care providers united in opposition, the bill is on hold and not moving with the fee schedule in place. The Governor has engaged health care leaders in a long term discussion on changing auto insurance payments to health care providers for patients before and after hospitalization. MIOTA members should remain vigilant in their opposition to the fee schedule but thank those legislators that stepped up to the plate for health care providers.

Another health care topic generating much discussion and debate in Lansing is implementation of the federal Patient Protection and Affordable Care Act (ACA for short). This act was signed by President Obama in early spring of 2010 has been divisive at the federal and state level. One of the requirement of the ACA is for states to create a health care exchange for individuals and small groups to purchase health care if their employer doesn't provide health care or they are self employed. Governor Snyder called for creation of the MiHealth Marketplace by the end of 2011. The Senate has passed their version of the exchange, SB 693, but the House has announced that they will not consider any proposal until the US Supreme Court rules on the validity of the ACA sometime next year. The creation of the exchange is important to all health care providers if the state wants to be in control of its own health care offerings once the ACA takes effect. MIOTA has been closely monitoring the exchange legislation throughout the year and will continue to do so in 2012.

One of the possible unintended consequences of the ACA is the future of Blue Cross/Blue Shield of Michigan. BCBSM is a creature of state law and is the state's "carrier of last resort" for health care. Another result of that designation under state law is that BCBSM is treated as a non-profit entity and, thus, exempt from most state taxes. Under the ACA, the federal and state government essentially become the carriers of last resort as it becomes their obligation to provide health care coverage for all citizens. This requirement has prompted some in state government to question the future role of BCBSM in a post-ACA market. Governor Snyder called for a review and discussion of BCBSM in his September health care message to the state. MIOTA will be fully engaged in any discussions regarding BCBSM and its role in the health care marketplace in Michigan in 2012.

As you can see, health care has continued to play a major role in debates in Lansing this year. MIOTA has been at the table throughout these discussions and will continue to do so in 2012. MIOTA can always use additional input from practicing OTs in the state and I welcome your involvement in the debate. If you have an interest in getting involved in MIOTA's legislative advocacy efforts, please contact me at bmarr@mhsa.com .

Hand SIS Lending Library

1. Appreciation of hand and forearm anatomy
2. Appreciation of shoulder anatomy
3. Anatomy and biomechanics of forearm and hand-G.Gola OTR,CHT, C.Reed OTR,CHT, Dr. Ditmars
4. Arthritis part I :related conditions-Dr. Mawby
5. Arthritis part II :Pharmaceutical mgmt., P.T. perspective of therapy and use of electric gloves
6. Arthritis part V: Pathomechanics of wrist, s/p mgmt. Of MP and PIP arthroplasty
7. Arthritis part VI: Pathomechanics of arthritic hand-J. Boozer OTR
8. Analytical approach to splinting-J. Baker OTR,CHT
9. Cervical spine-J. Fedorczyk P.T.
10. Comprehensive evaluation of the hand-M. Gilin OTR,CHT, D. Seidl OTR,CHT
11. Cryotherapy and heat tx-L. Miner OTR,CHT
12. CTD and CTS: Pathology and TX implications-E. Foley OTR,CHT, Dr. Horrell
13. DeQuervains: Pathology and TX implications-D. Seidl OTR,CHT
14. Degenerative wrist disorders :therapeutic mgmt. of arthritic wrist- Dr. Mehta, J. Boozer OTR,CHT
15. Difficult injury cases-D. Claiborne OTR,CHT
16. Dynamic splinting-S. Desilva OTR,CHT
17. Electrotherapy for pain control-J. Fedorczyk P.T.
18. Endoscopic carpal ligament release-surgery video
19. Evaluation and mgmt. of U.E. edema-C. Basil OTR,CHT, C. Hoban OTR,CHT
20. Flaps and grafts- Dr. Mehta
21. Flexor tendon injuries: TX theory and application-M. Gilin OTR,CHT
22. Flexor tendon anatomy, pathology, physiology-Dr. Pochran, H. Turkopp OTR,CHT, P. Trese OTR,CHT
23. Hand replantation at the wrist level: Treatment-R. Jordan OTR,CHT
24. Innervation of the upper limb-AGC educational media
25. Lateral epicondylitis-Dr. Burke, M. Gilin OTR,CHT
26. Long sustained stretch, paraffin and massage: Increasing burned shoulder AROM- T. Mozdzierz OTR
27. Management of the burned hand-N. Cox OTR,CHT
28. Management of the stiff hand-C. Vennix OTR, S. Merritt OTR,CHT, Y. Raducha OTR,CHT, S.Mannarino OTR,CHT
29. Management of the stiff elbow-Dr. King
30. Management of the U.E. amputation in the 90's-L. Miner OTR,CHT
31. Myofacial trigger point: theory and technique- M. Corrigan OTR,CHT, S. Kozub OTR,CHT
32. Median nerve compression: Lat/Med. Epicondylitis- Dr. Failla, Dr. Barbosa
33. Nerve mobilization-D. Seidl OTR,CHT
34. NMES: Electrotherapy for tissue healing and edema-J. Fedorczyk P.T.
35. Physiology of bone healing and distal fx-M. Horst OTR,CHT, Dr. McGraw
36. Principles of cold and heat-L. Miner OTR,CHT, L. LeBlanc OTR,CHT
37. Principles of ultrasound and electrotherapy- J. Fedorczyk P.T.
38. Radiographic (x-ray) reading-L. Winters R.T.
39. Replant of the hand- Dr. Busuito
40. RSD: etiology and treatment-H. Turkopp OTR,CHT, P. Flynn MS,OTR
41. RSD: pathology and treatment implications-Dr. Pierret, M. Gilin OTR,CHT
42. Silicone sports splint fabrication-K. Holtfreter OTR,CHT
43. Shld. Impingement, mobilization, tissue healing-B. Rinehimer P.T.,CHT
44. Shld. Provacative testing, joint mob. lab, rehab. concepts-B. Rinehimer PT,CHT, M. Walsch PT,MS,CHT
45. Shld. Biomechanics, proximal humerus FX, adhesive capsulitis-B. Rinehimer PT,CHT, M. Walsch PT,MS,CHT
46. Tendon transfers-Dr. Louis
47. Tendon transfers and therapeutic mgmt.-Dr. Failla, L. Contesti OTR,CHT
48. Therapist mgmt. of Lat/Med epicondylitis and nerve compression-S. Linder-Tons OTR,CHT, M. Gilin OTR,CHT
49. Therapeutic mgmt. of Thoracic Outlet Syndrome-R. Coughlin OTR,CHT
50. Thoracic Outlet Syndrome Part I: journal review, diagnosis, evaluation-Dr. Leslie
51. Thoracic Outlet Syndrome Part II: work modification, somatic dysfunction and it's relation to T.O.S.-. Scheyett PT, J. Lyon OTR, Dr. Duvernoy
52. Transdermal delivery of medication and ultrasound-J. Fedorczyk PT
53. Ulnar nerve anatomy, pathology and TX-Dr. Hing
54. Wrist fx, dislocation and instabilities-Dr. Dass, Dr. Barbosa
55. Wound mgmt. for health care professionals-A. Eisman OTR, L. Bonicki OTR

If you are interested in renting a video, please contact Rasa Poorman, OTR, CHT at Dwight Orthopedics (248)543-4886. The cost for rental is $3.00 for MOTA members and $5.00 for non-members plus postage. Thank you.

MiOTA Ballot for Executive Officers

Deadline for return of ballots is January 30, 2012

MiOTA Election Ballet

Membership Number_____(please enter your member number)

Vote for one (1) Finance Director (to serve for two years)

_____Denise Justice

_____ Write In _____

Vote for one (1) Communication Director (to serve for two years)

_____ Nancy Vandewiele Milligan

_____ Write In _____

Candidate Profiles

Denise Justice, OTR graduated from Eastern Michigan University in 1992 with a BS in occupational therapy. Four years prior she obtained an AS in occupational therapy from Schoolcraft College in Livonia, Michigan. She pursued her internship training at the University of Michigan.

Denise Justice has been employed with the University of Michigan Medical Center for more than 17 years. Her experience has primarily been in pediatrics with inpatients and outpatients. She is a clinical specialist. Her training includes feeding and swallowing, serial casting, splinting, sensory integration, prosthetic evaluation and training, kinesiotaping and functional electrical stimulation. Denise's patient experience ranges from clinical care to rehabilitation to acute care. She has treated patients in the neonatal intensive care, intensive care, acute care and rehabilitation situations. In her experience she has treated a variety of patient diagnoses. She now specializes in brachial plexus palsy. Denise Justice participates actively in the multi-disciplinary Pediatric Brachial Plexus Program.

Denise Justice is a member of the American Occupational Therapy Association and Michigan Occupational Therapy Association.

Special Interests: The treatment of pediatric brachial plexus and peripheral nerve disorders.

Personal Experiences: Denise Justice was the treasurer's assistant for 3 years at Livonia Co-Op Nursery where her three children attended preschool. For the past 2 years she has served on the Board of Directors for Livonia Gymnastics Academy as the secretary for two years and currently as the President.

Nancy Vandewiele Milligan, PhD, OTR

Nancy has served as the MiOTA communications director since 2006. During her time as Communications Director Nancy has focused her efforts to disseminate information to the MiOTA membership by organizing and sponsoring conferences and meetings around the state. Her efforts have helped raise over $7,000 of donations towards supporting MiOTA's licensure bill. If re-elected Nancy's goals for her next term would be to continue to focus on informing the membership about the rules and regulations regarding licensure for OT's and OTA's in Michigan.

Nancy is an assistant professor and the academic fieldwork coordinator at Wayne State University. In addition she serves on the Commission for Disability Issues for the city of Ann Arbor.

To complete your ballot:

1. Indicate your membership number in the space provided – found on your MiOTA membership card.
2. Indicate your vote by checking the name or completing the write in name. Please print legibly if entering a write in name. There must be previous consent from the person whose name is used as a write in and this person must be a MiOTA member.
3. Return your ballot to the MiOTA office:
   MiOTA
   124 West Allegan St.
   Suite 1900
4. Or Fax your ballot to MiOTA office:
   517-484-4442

Michigan Occupational Therapy Association
Inc.
124 W. Allegan St., Suite 1900
Lansing MI 48933

MiOTA

Look for us on the web
Mi-ota.com

MiOTA reserves the right to edit or reject articles and advertisements submitted for publication. In publishing the MiOTA Newsletter, MiOTA seeks to acquaint the reader with techniques, procedures and philosophy or material set forth, and does so primarily for informational and educational purposes and not for the purposes of promoting or sanctioning one technique, procedure, philosophy, etc., over another. MiOTA hereby disclaims any liability for the accuracy of material accepted for publication and included herein, and for the individual use or application of the procedures and techniques described. Acceptance of articles or advertisements does not imply endorsement by MiOTA.

The MiOTA Newsletter is always looking for article ideas or sharing from you what works in your practice area. If you have an idea to share contact Donna Case at casedo@northville.k12.mi.us

Deadlines for MiOTA Newsletter

Issue Deadlines:

Spring	April 01, 2012
Summer	July 01, 2012
Fall	October 01, 2012
Winter	January 01, 2013

Michigan Occupational Therapy Association, Inc.

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