OLR ACTS AFFECTING

HEALTH PROFESSIONS

Office of Legislative Research

Connecticut General Assembly

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2006-R-0349
June 20, 2006
NOTICE TO READERS

This report provides highlights of new laws (public acts) affecting health professions enacted during the 2006 regular legislative sessions. In each summary we indicate the public act (PA) number or, if that is not yet available, the act number.

Not all provisions of the acts are included here. Complete summaries of all 2006 public acts passed will be available in the fall when OLR’s Public Act Summary book is published; some are already on OLR’s webpage: http://www.cga.ct.gov/olr/.

Readers are encouraged to obtain the full text of acts that interest them from the Connecticut State Library, the House Clerk’s Office, or the General Assembly’s website: http://www.cga.ct.gov.
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ALZHEIMER’S SPECIAL CARE UNITS

PA 06-195 requires Alzheimer’s special care units or programs to disclose in writing to people who will live in them or their legal representative or other responsible party information about the its philosophy, costs, admission and discharge procedures, care planning and assessment, staffing, physical environment, residents’ activities, and family involvement. Disclosure must begin by January 1, 2007. The disclosure form must be signed by the patient or responsible party.

An “Alzheimer’s special care unit or program” is any nursing facility, residential care home, assisted living facility, adult congregate living facility, adult day care center, hospice, or adult foster home that locks, secures, segregates, or provides a special program or unit for residents with a diagnosis of probable Alzheimer’s disease, dementia, or similar disorder. The unit or program must be one that prevents or limits a resident’s access outside the designated or separated area and advertises or markets itself as providing specialized care or services for those with Alzheimer’s disease or dementia.

The act requires each special care unit or program to annually provide Alzheimer’s and dementia specific training to all licensed and registered staff who provide direct patient care to residents in these units or programs. This must include (1) at least eight hours of dementia-specific training, completed within six months after beginning employment, followed by three hours of such training annually and (2) at least two hours a year of training for direct care staff in pain recognition and administration of pain management techniques.

This takes effect October 1, 2006 for the disclosure provisions; upon passage for the training requirements.

ATHLETIC TRAINERS

For purposes of athletic trainer licensure, PA 06-195 references certification by the Board of Certification, Inc. or its successor instead of the National Athletic Trainers’ Association Board of Certification, Inc. It also specifies that the Department of Public Health (DPH) commissioner, before April 30, 2007, must license as an athletic trainer an applicant providing satisfactory evidence of (1) continuously providing services as an athletic trainer since October 1, 1979 or (2) being certified as an athletic trainer by the Board of Certification.

It authorizes DPH to take various disciplinary actions against a licensed athletic trainer failing to meet the profession’s accepted standards. These include license suspension or revocation, censure, a letter of reprimand, probation, or a civil penalty. DPH can order a licensee to submit to a reasonable physical or mental examination if his physical or mental capacity to practice safely is the subject of investigation. DPH can petition the Hartford Superior Court to enforce an order or action. The licensee must receive notice of any contemplated action, the cause of the action, and the opportunity and date for a hearing.
This takes effect upon passage, except that the provision concerning the April 30, 2007 date for certain licensure takes effect October 1, 2006.

BREAST CANCER SCREENING

PA 06-38 changes when health insurance policies must provide coverage for a comprehensive ultrasound screening of a woman’s entire breast or breasts. Under prior law, a policy had to provide coverage if a physician recommended the screening for a woman classified as category 2, 3, 4, or 5 on the American College of Radiology’s Breast Imaging Reporting and Database System (BI-RADS) mammogram reading scale. The act instead requires coverage if (1) a mammogram shows heterogeneous or dense breast tissue based on BI-RADS or (2) a woman is considered at an increased breast cancer risk because of family history, her own prior breast cancer history, positive genetic testing, or other indications determined by her physician or advanced-practice registered nurse. By law, unchanged by the act, coverage for breast ultrasound screening is subject to any policy provisions applicable to other covered services and is in addition to coverage required for mammograms.

The act applies to individual and group health insurance policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including those provided by HMOs. The act also applies to individual policies that cover (1) accidents only and (2) limited benefits.

This takes effect October 1, 2006.

CERTIFICATE OF NEED

PA 06-28 raises to $3 million the capital and major medical equipment expenditure threshold that triggers an Office of Healthcare Access (OHCA) certificate of need (CON) review. The previous threshold was $1 million for capital costs and $400,000 for major medical equipment.

The higher threshold does not affect the acquisition of imaging equipment, such as a CT or PET scanner, which is subject to CON review regardless of cost unless it was purchased or leased for under $400,000 before July 1, 2005. But the act conditions this exemption by specifying that the equipment must be in operation before July 1, 2006.

This takes effect July 1, 2006 for the higher CON threshold and upon passage for the provision affecting the CON exemption for imaging equipment.

PA 06-64 makes a number of changes to OHCA’s CON program. The act amends the CON process by (1) modifying the letter of intent phase of CON in emergency situations, (2) allowing OHCA to waive CON for specific termination or relocation of certain services, and (3) modifying the existing waiver from CON for replacement equipment.

The act also makes a number of minor and technical changes to OHCA statutes. It extends the time by which hospitals must report certain information to OHCA, changes some of the salary and benefits data they must report, and modifies their reporting of uncompensated care information. It also repeals several statutory provisions.
concerning obsolete budget and net revenue system procedures and references to the uncompensated care pool.

This takes effect July 1, 2006.

CLINICAL LABORATORIES

PA 06-90 (as amended by PA 06-196) excludes from the Connecticut insurance code’s definition of a “preferred provider network” (PPN) clinical laboratories licensed by DPH whose primary payments for contracted or referred services are made to other licensed laboratories or for associated pathology services. By law, the insurance commissioner licenses and regulates PPNs. Consequently, the act excludes such laboratories from PPN requirements.

This takes effect upon passage.

DENTISTS

Malpractice Insurance

PA 06-195 requires dentists who provide direct patient care services to maintain professional liability insurance or other indemnity against liability for professional malpractice. The amount each dentist must carry against claims for injury or death for malpractice must be at least $500,000 for one person, per occurrence, with an aggregate of at least $1.5 million.

Beginning January 1, 2007, each insurance company issuing professional liability insurance must provide DPH with a true record of the names and addresses, by classification, of cancellations of, and refusals to renew, professional liability insurance policies, including the reasons for cancellation or refusal, for the year ending on the preceding December 31.

Under the act, a dentist who must carry malpractice insurance is deemed in compliance when providing dental services at a DPH-licensed, tax exempt clinic (under § 501(c)(3) of the IRS Code) if the dentist is not compensated and the clinic:

1. does not charge patients for services,
2. maintains professional liability insurance coverage in the required amounts for each aggregated 40 hours (or fraction of) for the dentists,
3. carries additional appropriate professional liability coverage for itself and its employees of $500,000 per occurrence with an aggregate of not less than $1.5 million, and
4. maintains total professional liability coverage of at least $1 million per occurrence with an annual aggregate of at least $3 million.

But a dentist is subject to the insurance requirements when providing direct patient care services in any setting other than the clinic. The act specifies that it does not relieve the clinic from any other insurance requirements of law.

Under the act, a dentist insured with a claims-made medical malpractice insurance policy does not lose the right to unlimited additional extended reporting period coverage when he permanently retires from practice if he solely provides professional services without charge at a tax-exempt clinic.

This takes effect October 1, 2006.
Continuing Education

PA 06-195 specifies that the 25 hours of continuing education dentists must take every two years, beginning October 1, 2007, include at least one hour in each of the following topics: infectious diseases, access to care, risk management, special needs populations, and domestic violence.

This takes effect upon passage.

DIALYSIS PATIENT CARE TECHNICIANS

PA 05-66, which allows dialysis patient care technicians employed in outpatient dialysis units to administer certain medications, did not require DPH to license or certify the technicians. PA 06-195 repeals references to dialysis patient care technicians in a statute (CGS § 19a-14) that identifies those health professions for which there are no boards or commissions and provides DPH with regulatory oversight over them. The act allows technicians to administer limited medications in hospital dialysis units, as well as outpatient dialysis units, under the supervision of a registered nurse as necessary to initiate or conclude hemodialysis treatment. The act also makes a technical change to recognize that technicians must be certified as such by an organization approved by DPH.

This takes effect October 1, 2006.

EMERGENCY MEDICAL SERVICES

Model Guidelines for Volunteering

PA 06-22 requires the state fire administrator, within available appropriations, to develop model guidelines by January 1, 2007, that municipalities with paid or volunteer emergency personnel may use to enter into agreements allowing people to serve as volunteer emergency personnel during their personal time. Currently, labor contracts in several municipalities restrict or bar paid firefighters from serving as volunteer firefighters in other municipalities.

This takes effect upon passage.

Certificate of Need

PA 06-195 grants primary service area responders (PSAR) intervenor status in DPH hearings on the need for new or expanded EMS service in their area and establishes an expedited process for certain PSARs to add ambulances to their fleets. Intervenor status, including the opportunity to cross examine witnesses, must be granted to a PSAR if the hearing deals with new or expanded service in a town it serves and the PSAR asks for this status.

The act permits a licensed or certified volunteer municipal ambulance service that is a PSAR to add one emergency vehicle every three years without having to go through the otherwise required public hearing on the request. The one vehicle limit applies to the provider’s entire fleet regardless of the number of town it serves.

When it applies for this expedited review, the volunteer municipal PSAR must give written notice to all other PSARs in towns where the applicant proposes to add the vehicle and those abutting them. If one of them requests a hearing within 15 calendar days after receiving notice, DPH must hold a hearing; if none object, the application is deemed approved 30 calendar days after it is filed.
The act requires an entity (which includes an ambulance, rescue, or management service), within six months after the date DPH approves its request for new or expanded services, to (1) acquire the resources, equipment, and other material it needs to comply with the terms of approval and (2) operate in the area identified in its application. Failure to do either within six months voids the approval, which DPH must rescind.

This takes effect upon passage.

EMS Management Services

PA 06-195 also specifies that EMS management services organizations, which provide personnel to EMS providers, are employment organizations and may not own or lease ambulances or other emergency vehicles. The law requires DPH to license these organizations, and the act explicitly subjects them to DPH disciplinary action if they violate DPH regulations or fail to maintain required standards and permits them to appeal DPH disciplinary or other licensing actions under the Uniform Administrative Procedures Act. These disciplinary actions include license or certification suspension or revocation, probation, and a civil penalty of up to $10,000.

The act also requires all ambulance services to secure and keep medical control by a sponsor hospital for all their EMS personnel, whether they or a management service employ them.

This takes effect upon passage.

EMS Reporting Requirements

PA 06-195 changes the information public safety answering points are required to report. Instead of reporting the calls they receive for EMS services and the 9-1-1 calls they receive involving medical services, it requires them to report all calls they receive through the 9-1-1 system for services. And, instead of reporting the time that elapsed between answering a call and dispatching services or relaying it to another public or private safety agency, they must report the elapsed time until they transfer or terminate a call. Finally, the act removes the requirement that they report this information quarterly to DPH.

This takes effect upon passage.

FUNERAL HOMES AND DIRECTORS

PA 06-195 requires every funeral home to maintain at its address of record for inspection purposes copies of all records relating to funeral service contracts, prepaid funeral contracts, or escrow accounts for at least three years after the death of the person for whom the funeral services were provided.

This takes effect October 1, 2006.

Prior law required the funeral director to notify to the local registrar of vital records who issued the cremation permit about the method of disposition of unclaimed cremated remains. PA 06-195 instead requires that the funeral director give notice to the registrar of the town where the person died.

This takes effect upon passage.

PA 06-195 requires the person or entity that holds a DPH certificate to operate a funeral home to notify owners of prepaid funeral contracts, people for whom it is holding cremated remains, and DPH when more than 50% of the business is transferred or the business is discontinued or terminated. The person or entity must:
1. notify each owner of a prepaid funeral contract;
2. mail a letter to anyone for whom the home is storing cremated remains; and
3. give DPH, within 10 days of the transfer, discontinuance, or termination, a list of all unclaimed cremated remains the home held at that time.
This takes effect October 1, 2006.

HEALTH CARE DECISION-MAKING

PA 06-195 amends and updates Connecticut law on health care decision making by:

1. combining the authority of the health care agent and attorney-in-fact for health care decisions into a unified proxy known as the “health care representative”;
2. expanding the scope of a living will from covering only decisions concerning life support to include any aspect of health care;
3. conferring on the health care representative the authority to make any and all health care decisions for a person incapable of expressing those wishes himself;
4. clarifying that (a) a conservator must comply with the previously executed advance directives of a ward and (b) a decision of a health care representative takes precedence over that of a conservator;
5. providing for recognition of advance directives validly executed elsewhere that are not contrary to Connecticut policy; and
6. specifying that advance directives properly executed before October 1, 2006 remain valid.
This takes effect October 1, 2006.

HOME HEALTH CARE

PA 06-188 requires the Department of Social Services (DSS) commissioner to provide Medicaid reimbursement for children’s home health care services provided in the child’s home or a “substantially equivalent environment.” The act specifies that the latter setting can include, at a minimum, licensed child day care facilities and after-school programs. It is not clear whether federal Medicaid matching funds would be available for services provided outside the recipient’s home since the regulations (42 CFR § 440.70) define home health services for Medicaid reimbursement purposes as those services provided at the place of residence.

As a result of a recent court case, DSS agreed to pay for skilled nursing services provided outside of the home. The agreement says nothing about home health aide services.

This takes effect July 1, 2006.

By law, the DSS commissioner must establish prior authorization (PA) procedures in the Medicaid program for home health care. Prior law specified that (1) PA was required for more than two skilled nursing visits per week and (2) providers could not be required to submit PA request more than once a month unless the PA was revised during that month. PA 06-188 adds PA for home health aide visits that exceed 14 hours per week. (Currently, DSS policy allows up to 20 hours of home health services per month.)
aide services per week without PA.) And it allows providers to submit PA requests no more than once a month but only if they are for the same client.

This takes effect July 1, 2006.

HOSPITALISTS

PA 06-195 requires the best practices subcommittee of the Quality of Care Advisory Commission, which advises DPH on ways to measure health care facilities’ clinical performance, to make recommendations concerning communications between patients’ primary care providers and other providers involved in patient care, including specialists and hospitalists. The commission must make its recommendations to DPH by January 1, 2008. Hospitalists are physicians, mainly internists, whose primary professional focus is the general medical care of hospitalized patients.

This takes effect October 1, 2006.

HOSPITALS

Infection Reporting

PA 06-142 creates an 11-member Committee on Healthcare Associated Infections to develop, operate, and monitor a mandatory reporting system for healthcare associated infections.

The act defines a “healthcare associated infection” as any localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent or its toxin that (1) occurs in a patient in a healthcare setting; (2) was not found present or incubating at the time of admission unless it was related to a previous admission to the same setting; and (3) if the setting is a hospital, meets the criteria for a specific infection site, as defined by the National Centers for Disease Control. The act requires DPH to implement the committee’s recommendations concerning a mandatory reporting system for infections and standardized data reporting measures. It also establishes reporting requirements.

This takes effect upon passage.

Performance Improvement Plans

The law requires hospitals to implement performance improvement plans. PA 06-195 requires them to make their plans available to DPH at its request, rather than submit them annually as a condition of licensure.

This takes effect October 1, 2006.

Adverse Event Reporting

PA 06-195 specifies that the form the DPH commissioner prescribes for hospitals and outpatient surgical facilities to report adverse events, does not have to be adopted in regulation.

This takes effect October 1, 2006.

Alcohol and Substance Abuse Reporting

PA 06-195 requires hospitals annually to send the protocols they use to screen patients for alcohol and substance abuse only to the Department of Mental Health and Addiction Services (DMHAS), rather than to both it and DPH.

This takes effect October 1, 2006.

HYPNOTISTS

PA 06-107 makes it sexual assault for hypnotists to have sexual intercourse or contact with clients under the same
circumstances that currently apply to others who perform or purport to perform psychotherapy. (PA 06-187 has the identical provision.)

This conduct is 2nd-degree sexual assault when it involves sexual intercourse:
1. with a client during a treatment session for a mental or emotional illness, symptom, or condition;
2. the hypnotist represents to be for legitimate treatment purposes; or
3. with a client or former client who is emotionally dependent on him.

By law, people convicted of this crime must comply with sex offender registration requirements for 10 years.

The act also makes it 4th-degree sexual assault to have sexual contact with a client or former client under the circumstances listed above.

This takes effect October 1, 2006.

PA 06-187 requires anyone practicing hypnosis, or holding himself out to be a hypnotist, to register with the Department of Consumer Protection (DCP). It defines “hypnosis” as an artificially induced altered state of consciousness characterized by heightened suggestibility and receptivity to direction.

It requires a registration applicant to state that he is not required to register as a sexual offender and requires the DCP commissioner to revoke, after notice and hearing, the registration of anyone required to register as one. It sets application, complaint handling, and disciplinary procedures. It authorizes the DCP commissioner to impose a civil penalty of up to $100 for practicing hypnosis without being registered and to adopt regulations in consultation with the DPH commissioner.

This takes effect October 1, 2006.

IMAGING SERVICES

PA 06-180 limits the copayments that can be imposed on a person for all magnetic resonance imaging (MRI), computed axial tomography (CAT) scan, and positron emission tomography (PET) scan services performed in-network. It limits the copayments for MRIs and CAT scans to no more than (1) $375 for all such services annually and (2) $75 for each one. It limits the copayments for PET scans to no more than (1) $400 for all such scans annually and (2) $100 for each one.

These copayment limits do not apply (1) if the physician ordering the imaging service performs it or is in the same practice group as the physician who performs it and (2) to high deductible health plans designed to be compatible with federally qualified health savings accounts.

The act applies to health insurers, HMOs, hospital service corporations, medical service corporations, and fraternal benefit societies providing group or individual coverage for such imaging services.

This takes effect October 1, 2006.

INVESTIGATION OF HEALTH CARE PRACTITIONERS

PA 06-195 gives DPH access to records maintained by insurance companies for review during the course of investigating a health care practitioner.

This takes effect October 1, 2006.
KIDNEY DISEASE SCREENING

**PAs 06-120 and 06-195** impose certain requirements, beginning September 1, 2006, on licensed physicians, hospitals, and clinical laboratories concerning testing of patients age 18 and older for kidney disease.

It requires physicians to order a serum creatinine test as part of the patient’s annual physical examination if the patient has not had such a test within the preceding 12 months. (Creatinine is a breakdown product of creatine, which is an important part of muscle. A serum creatinine test measures the amount of creatinine in the blood.) The physician’s test order must include a notification that it is being done according to the act’s provisions.

**PA 06-120** requires hospitals to order this test for each admitted patient, at least once during the patient’s stay. The test order must include the same notification as above. **PA 06-195** amends this to instead require that if a serum creatinine test is performed on a patient admitted to a hospital as an inpatient, the ordering provider must request at least once during the patient’s stay that the testing laboratory report an estimated glomerular filtration rate (eGFR). GFR measures how effectively the kidneys are removing waste and excess fluid from the blood. It is calculated based on a blood test for creatinine.

A clinical laboratory, when it tests a specimen to determine a patient’s serum creatinine level as ordered by a physician or hospital provider, must (1) calculate the patient’s eGFR using the patient’s age and gender which the physician or hospital provider must provide and (2) include the patient’s eGFR with its report.

This takes effect upon passage.

LOAN REPAYMENT PROGRAM

The law authorizes DPH to establish, within available appropriations, a program providing three-year grants to community-based, primary care service providers to expand access to health care for the uninsured. The grants may be awarded to recruit and retain primary care clinicians and registered nurses through salary subsidies or a loan repayment program. By law, participating clinicians and nurses must provide services to the uninsured based on a sliding fee schedule, provide free care if necessary, accept Medicare assignment, and participate as a Medicaid provider. **PA 06-195** specifies that these providers can also provide nursing services in a school-based health center.

This takes effect July 1, 2006.

LOCAL HEALTH DIRECTORS

**PA 06-81** tightens drinking water pollution notice requirements by requiring (1) sellers of homes that are or will be served by well water to notify prospective buyers of the results of any water test for volatile organic compounds and (2) the Department of Environmental Protection (DEP) commissioner to notify state, federal, and employee representatives about contaminated sites.

It sets various deadlines by which the recipient of the commissioner’s order to test any private drinking well must notify the property owner, local health director, and others of findings of excessive contaminant levels.
MEDICAL MALPRACTICE

**PA 06-108** limits the circumstances under which insurers must provide certain medical malpractice insurance coverage at no cost to physicians, surgeons, advanced practice registered nurses, physician assistants, and hospitals. It does this by (1) eliminating the requirement that policies issued on a claims-made basis provide prior acts coverage under certain circumstances and (2) changing the conditions under which policies must provide unlimited extended reporting period coverage. A claims-made policy covers a claim filed during the policy period as long as the incident on which the claim is based occurred after the retroactive coverage date specified in the policy. If no retroactive date is identified, the policy covers injury or damage occurring prior to the policy effective date.

This takes effect October 1, 2006.

NURSES

**PA 06-169** allows advanced practice registered nurses (APRNs) to request, receive, and dispense sample medications in all health care settings. Prior law allowed APRNs to do this only in noninstitutional settings (i.e., a physician’s office).

This takes effect October 1, 2006.

**PA 06-195** permits a graduate (APRN) to work without a license for 120 days after graduating in a hospital or other setting under the supervision of a physician or other APRN. The graduate APRN cannot prescribe or dispense drugs. The hospital or other setting must verify that the graduate has applied to take the national certification exam and must end his work if it is notified that he failed the exam.

This takes effect upon passage.

NURSE-MIDWIVES

**PA 06-195** revises nurse-midwives’ scope of practice and their relationship with physicians. It expands their scope to include all women’s health care needs; previously their scope was limited to gynecology, pregnancy, childbirth, and post-partum care of mothers and newborns. It removes the restriction that nurse-midwives care only for essentially normal newborns and women and only under an obstetrician-gynecologist’s (OB-GYN) direction. And it specifies that (1) their scope includes family planning and (2) they practice in collaboration with qualified ob-gyns.

It eliminates the requirement that the clinical relationship between a nurse-midwife and a physician be based on written protocols and guidelines that contain a list of the drugs, devices, and
lab tests a nurse-midwife can prescribe, administer, or dispense. Instead, it requires them to practice within a health care system and have a clinical relationship with ob-gyns that provide for consultation, collaborative management, or referral as indicated by the patient’s health status. It requires each nurse-midwife to provide (1) care consistent with standards the American College of Nurse Midwives establishes and (2) information about, or referral to, other providers or services, if the patient asks or requires care that is not in the nurse-midwife’s scope of practice.

The act permits a graduate of a nurse-midwife program approved by the American College of Nurse Midwives to practice midwifery without a license in a hospital or other facility for up to 90 days after graduation or until he learns that he failed the licensing exam. The facility must (1) verify the graduate’s successful completion of an approved program and (2) provide supervision the DPH commissioner determines is adequate.

Finally, the act requires the nurse-midwives the DPH commissioner appoints to advise him in regulating the profession be licensed and have practiced for at least five years. It prohibits any of them from being an officer in the Connecticut Chapter of the American College of Nurse Midwives.

This takes effect October 1, 2006.

NURSING FACILITY MANAGEMENT SERVICES

The act requires DPH to certify nursing facility management services. It defines these as services provided in a nursing home to manage the home’s operations, including providing care and services. It prohibits anyone from providing these services after January 1, 2007 without a certificate. Anyone seeking a certificate, or to renew one, must apply to DPH on a form it prescribes and pay a $300 fee.

DPH must base its certification decision on the information presented to it and on the managed nursing home’s compliance status. DPH can deny an applicant certification for any specific facility where there has been substantial noncompliance with the Public Health Code. Renewals must be made biennially after (1) submission of the required information and any other information DPH requires and (2) submission of satisfactory evidence that the nursing facility where the applicant provides management services substantially complies with the law on health care institution licensure and the Public Health Code, and (3) payment of $300.

If DPH finds substantial noncompliance with the act’s requirements, the commissioner can initiate disciplinary action against the management services certificate holder. DPH can limit or restrict the management services provided by a certificate holder against whom it has begun disciplinary action.

This takes effect July 1, 2006.

PHARMACISTS AND PHARMACIES

Electronic Prescription Drug Monitoring

**PA 06-155** requires the DCP commissioner, within available appropriations, to establish an electronic prescription drug monitoring program to collect prescription information from pharmacies about Schedules II, III, IV, and V controlled substances. The
program must be designed to provide information about the prescription of these substances to prevent their improper or illegal use. It prohibits the program from infringing on legitimate prescriptions of controlled substances made in good faith and in the course of professional practice.

The act (1) sets requirements for information reporting, (2) makes the information confidential and establishes a mechanism allowing it to be reported, and (3) establishes a prescription drug monitoring working group and sets its duties. It requires the commissioner to adopt regulations about reporting, evaluating, managing, and storing electronic controlled substance prescription information.

In addition, the act requires a pharmacist or his agent to require the presentation of valid photographic identification before releasing a controlled substance to anyone he does not know. It exempts from this requirement transactions taking place in an institutional or long-term care setting, including an assisted living facility or hospital.

This takes effect October 1, 2006.

**Pharmacy Reimbursement and Dispensing Fees**

**PA 06-188** requires DSS, in consultation with the Connecticut Pharmacists Association, to review the impact of its implementing the average manufacturer price (AMP) reimbursement methodology, which it must do by January 1, 2007, as required by the federal Deficit Reduction Act (DRA) of 2005 (PL 109-171). The review must include, at a minimum (1) the financial impact of the required change on pharmacy reimbursement for the Medicaid fee-for-service program and (2) recommendations for potential changes in the dispensing fee for generic and brand name drugs.

Based on the study’s outcome, starting April 1, 2007 but only for FY 07, DSS may, after OPM gives its approval, adjust the dispensing fee it pays pharmacists under all of its drug assistance programs (i.e., Medicaid, ConnPACE, and AIDS drug assistance).

The act authorizes DSS, with OPM approval, to increase the dispensing fee to pharmacies participating in these drug assistance programs and the State-Administered General Assistance program to indemnify and hold harmless those pharmacies that experience financial hardship as a result of the AMP changes.

The DRA requires the federal Medicaid agency to use the AMP as the basis for calculating the federal upper limit for generic drugs under Medicaid. Typically, most states, including Connecticut, reimburse pharmacies at a discount off the drug’s average wholesale price (DSS currently pays the average wholesale price, minus 14% plus a $3.15 dispensing fee). This change is expected to reduce Medicaid revenues to pharmacies by reducing their payments for ingredient costs.

This takes effect July 1, 2006.

**PA 06-188** allows the DSS commissioner to reimburse pharmacies and pharmacists for prescription drug costs in unit dose packaging, including blister packs and other special packaging, for clients residing in nursing facilities, chronic disease hospitals, and ICF-MRs.

This takes effect July 1, 2006.
Pharmaceutical Emergency Preparedness

When the governor or her authorized representative declares an emergency, 
**PA 06-195** allows a hospital pharmacy, pharmacy, or registrant authorized by state or federal law to possess controlled substances to transfer or distribute drugs or controlled drugs to a licensed pharmacy, registrant, or a location authorized by the DCP commissioner. This must be done according to applicable federal law, regulations, guidelines, and policy and with the commissioner’s prior approval. The registrant must record the transfer accurately in compliance with all state and federal law and report the transfer in writing to the commissioner.

The act requires licensed wholesalers that distribute prescription drugs to provide the commissioner with a report on their on-hand inventory of specifically identified prescription drugs. Licensed repackagers of the finished form of the drug must do the same.

This takes effect upon passage.

**PHYSICAL THERAPISTS AND PHYSICAL THERAPY ASSISTANTS**

Treatment without Referral

**PA 06-125** allows physical therapists meeting certain standards to treat patients without referral from another health care practitioner, except in cases involving workers’ compensation injuries and a specific kind of treatment. The act establishes procedures a physical therapist must follow in treating patients without a referral. **(PA 06-195 amends provisions of PA 06-125 concerning the education a physical therapist needs to**

Malpractice Insurance

**PA 06-195** requires licensed physical therapists who provide direct patient care to carry malpractice insurance of at least $500,000 per person, per occurrence with an aggregate of at least $1.5 million. It requires malpractice insurers, beginning January 1, 2007, to annually notify DPH of the names and
addresses of physical therapists whose
policies it cancelled or refused to renew
in the previous calendar year and the
reasons why.

This takes effect October 1, 2006.

**Physical Therapy Assistants**

**PA 06-195** alters two conditions
under which DPH can license a physical
therapy assistant (PTA) without an
examination. It permits DPH to issue a
license (1) before April 30, 2007, to
people who show that they had worked
for 20 years as a PTA before October 1,
1989 or (2) to people who were
registered PTAs before April 1, 2006.
Under prior law, DPH could license
without an exam a person who was
eligible to register as a PTA when DPH
notified the public that it had adopted
PTA licensing regulations (it did so on
April 11, 2006), had graduated from an
approved physical therapy school, or had
worked 20 years as a PTA by October 1,
1989. DPH continues to be able to
license without an exam anyone who is
licensed or registered in another state or
nation with similar or higher
requirements than Connecticut.

This effect upon passage

**PHYSICIANS**

**Contracts**

**PA 06-178** requires each contracting
health organization (managed care
organization (MCO) or PPN) to
implement a procedure by October 1,
2007 under which a contracted
physician, physician group, or physician
organization may view the fee schedule
that determines the payment amount for
the most commonly performed and
billed services. It also requires the

chairpersons and ranking members of
the Insurance Committee to meet at least
twice a year with physicians and MCOs
to discuss issues regarding their
contracts, including any national
settlement agreements arising from
recent lawsuits by physicians against
MCOs, to the extent permitted by the
agreements.

This takes effect October 1, 2006.

**Continuing Education**

**PA 06-195** specifies that the 50
hours of continuing education physicians
must take every two years, beginning
October 1, 2007, include at least one
hour in each of the following topics:
infectious diseases, risk management,
sexual assault, and domestic violence.

That takes effect upon passage.

**Use of “Doctor” Title**

**PA 06-195** amends the law on use of
the title “doctor” and related terms and
abbreviations. It prohibits anyone
engaged in any branch of the art of
healing the sick or injured or claiming to
do so, other than a licensed medical
doctor, from using or implying the use
the terms “physician,” “surgeon,”
“medical doctor,” “osteopath,” or
“doctor,” or the initials “M.D.”, “D.O.”,
or “Dr.,” or any similar title or
description of services with the intent to
represent or likely have someone believe
that the person (1) practices medicine in
the state, (2) is licensed to practice
medicine in the state, or (3) may
diagnose or treat any injury, deformity,
ailment or disease, actual or imaginary,
of another person for compensation,
gain, or reward.
Under the act, a person who has a doctor of medicine or osteopathy degree, but is not licensed to practice medicine under state law, may use the initials “M.D.,” or “D.O.,” if his intent is not to represent or induce the belief that he (1) practices or is licensed to practice medicine in the state, or (2) may diagnose or treat any injury, deformity, ailment, or disease of another person for compensation, gain, or reward.

Violation of these provisions or of existing law on who may legally practice medicine results in a fine of up to $500, imprisonment up to five years, or both. The act specifies that (1) each instance of patient contact or consultation in violation of the physician practice law constitutes a separate offense and (2) failure to renew a license is not a violation of the act.

This takes effect upon passage.

PHYSICIAN ASSISTANTS

PA 06-110 revises the supervision requirements for physician assistants (PAs) by (1) making a distinction between supervision in a hospital versus other settings and (2) eliminating a requirement that the supervision in any setting be at the specific location where the PA is practicing. By law, each PA must have a clearly identified supervising physician, registered with DPH, who has final responsibility for patient care and the PA’s performance. A physician may supervise up to six full-time PAs concurrently or the equivalent part-time number, if medically appropriate.

The law requires the supervising physician to personally review the PA’s practice at least weekly or more frequently as needed to ensure quality care. In settings other than hospitals, the act requires (1) that these reviews be done through face-to-face meetings, at least weekly or more frequently as necessary to ensure quality care, at a facility or location where the PA or supervising physician practices and (2) that the supervising physician document in writing his already-required regular review of the PA’s charts and records at the facility or practice location of the PA or physician.

The act also specifies that, in any setting, a physician designated as the PA’s alternate supervising physician when his regular supervising physician is absent must be registered with DPH.

This takes effect October 1, 2006.

PODIATRISTS

PA 06-160 expands the scope of practice of podiatrists by allowing the medical and nonsurgical treatment of the ankle under certain conditions. Podiatrists’ previous scope was limited to diagnosis and treatment of ailments of the foot, including medical and surgical treatment, and administering and prescribing drugs incidental to this care.

The act requires the DPH commissioner to convene a panel, directed by an arbitrator, to develop a protocol and recommendations for allowing qualified podiatrists to perform surgery on the ankle.

This takes effect October 1, 2006 for the scope of practice changes and upon passage for the panel.

PROFESSIONAL COUNSELORS

The act changes the education criteria required for a person seeking a professional counselor’s license. Under prior law, a person must have completed
60 hours of graduate school work in counseling-related areas and have earned a master’s degree, a master’s degree and a sixth year degree, or a doctorate. The act, instead, requires licensure candidates to have accomplished one of the following:

1. completed 60 hours of graduate school work in counseling-related areas;
2. earned (a) a master’s degree with at least 42 graduate hours with a major the National Board of Certified Counselors deems to be in the discipline of counseling or (b) a master’s degree with a major in social work, marriage and family therapy, counseling, psychology, or a mental health field plus a sixth year degree in a discipline deemed as counseling by the national board; or
3. a doctorate in a discipline the national board deems to be counseling.

This takes effect October 1, 2006.

PROVIDER APPEAL PROCEDURES—BEHAVIORAL HEALTH PARTNERSHIP (BHP)

**PA 06-188** requires the Department of Children and Families and DSS to develop provider appeal procedures for the BHP and likewise renames the existing procedures they must develop for consumer appeals, rather than grievances. It requires these procedures to include those for a consumer or a provider acting on his behalf to appeal a denial or a determination.

This takes effect October 1, 2006.

RADIOGRAPHERS

Beginning October 1, 2008, **PA 06-195** requires radiographers, in order to renew their license, to attest in writing that they (1) are registered by a professional organization or (2) have earned at least 24 contact hours of continuing education in the previous 24 months. A contact hour is at least 50 minutes of education activity. Anyone who fails to do this is subject to disciplinary action, including license revocation or suspension. An individual who does not take the continuing education path must register as a radiographer or radiation therapy technologist with the American Registry of Radiologic Technologists. Continuing education must be in the individual’s practice area and reflect his professional needs in order to meet the public’s health care needs.

The act exempts from its continuing education requirements first-time license renewal applicants and those not engaged in active practice. It permits the DPH commissioner to waive continuing education requirements or extend the time for fulfilling them for a radiographer who is ill or disabled.

A radiographer who applies to have his license reinstated after it has lapsed must show DPH that he completed 12 contact hours during the preceding year.

This takes effect October 1, 2006.

RESPIRATORY CARE PRACTITIONERS

**PA 06-195** establishes continuing education requirements for respiratory care practitioners. A licensee applying for renewal for registration periods beginning on and after October 1, 2007,
must maintain either (1) credentialing as a respiratory therapist (which presumably is the same as a respiratory care practitioner) from the National Board for Respiratory Care, or its successor, or (2) earn a minimum of six contact hours of continuing education within the preceding registration period. (A registration period is the one-year period for which a renewed license is current and valid; a “contact hour” is a minimum of 50 minutes of continuing education). The continuing education must be directly related to respiratory therapy and reflect the licensee’s professional needs in order to meet the public’s health care needs. Qualifying continuing education includes courses (including on-line courses) offered or approved by the American Association for Respiratory Care, regionally accredited higher education institutions, or a state or local health department.

In his discretion, the DPH commissioner may waive the continuing education requirements or grant an extension to fulfill them in cases of medical disability or illness. DPH can take disciplinary action against a respiratory care practitioner failing to comply with the continuing education requirements. This can include license revocation or suspension, censure, letter of reprimand, probation, and civil penalties.

The act also allows respiratory care practitioners on active duty in the armed forces to renew their licenses when they become void for up to one year from the date of discharge, once they complete six contact hours of continuing education. A licensee applying for renewal must submit an application on a DPH-prescribed form and other documentation the department may require.

This takes effect October 1, 2006.

UTILIZATION REVIEW

Prior law required a utilization review company to have a licensed practitioner of the medical arts certify appeal determinations to disapprove an admission, service, procedure, or extend hospital stay. PA 06-54 instead requires a licensed practitioner of the healing arts to certify the determination. Connecticut statutes define the practice of “healing arts” as the practice of medicine, chiropractic, podiatry, natureopathy, and optometry.

This takes effect October 1, 2006.

VETERINARIANS

PA 06-105 allows the agriculture commissioner, his designee, or the state veterinarian to grant an exemption from the rabies vaccine requirement, when a licensed veterinarian determines that a cat or dog may be harmed by vaccination due to disease or other medical considerations. The exemption is valid for one year, after which it must be renewed or the animal must receive the vaccination. The act specifies the process for granting the exemption.

This takes effect October 1, 2006.

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