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Occupational Therapist Licensure Revocation by State Licensing Boards

Abstract

Occupational therapists must abide by certain standards to maintain a license to practice. Despite the existence of various studies on licensure revocation in other health care professions, no prior research has been conducted regarding occupational therapist licensure revocations. The purpose of this study was to examine reasons for occupational therapy licensure revocations in the United States from 2005 to 2015. A retrospective descriptive study design was completed. Data were collected from public databases on state websites or through communication with state licensure board representatives. From 2005 to 2015, 65 occupational therapists had their licenses revoked in 40 states and the District of Columbia. Fraud and criminal conviction were the two most frequently cited reasons for licensure revocations in the majority female sample. The south region of the United States displayed the most license revocations when compared to other regions. The results of this study may enhance the education of occupational therapists, occupational therapy assistants, and students about ethical decision-making in practice. A standardized protocol used by all states in determining licensure revocation is recommended. Additional research on all occupational therapy disciplinary actions could further benefit occupational therapy curricula.

Comments

The authors report they have no conflicts of interest to disclose.

Keywords

disciplinary action, licensure revocation, fraud

Cover Page Footnote

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Every occupational therapist in the United States is required to obtain a state license to practice and deliver occupational therapy services. This license acknowledges that an individual has met the requirements to practice in the field of occupational therapy (American Occupational Therapy Association [AOTA], 2016). Each state may have unique requirements that an occupational therapist must meet to maintain his or her license (AOTA, 2016). Despite these state requirements and the AOTA guidelines for ethical practice, occupational therapists continue to face disciplinary actions related to unethical and error-based practice (AOTA, 2015a).

Literature Review

For an occupational therapist to obtain an occupational therapy license in the United States, he or she must have graduated from an Accreditation Council for Occupational Therapy Education accredited program, successfully completed fieldwork requirements, and passed the National Board for Certification in Occupational Therapy (NBCOT) certification exam (AOTA, n.d.; AOTA, 2016). When an occupational therapist passes the NBCOT exam and obtains licensure, he or she becomes an OTR/L, meaning the occupational therapist is registered (R) and licensed (L) (AOTA, 2016; NBCOT, 2017). The occupational therapist must complete a unique state application and pay a fee to be licensed (AOTA, 2016). Beyond these three requirements, there are specific requirements unique to holding a license in each state (AOTA, 2016). Many states require licensed practitioners to maintain competence by completing continuing education courses; however, the number of hours and the time frame in which courses must be completed vary by state (AOTA, 2015c). There are also state regulated requirements for renewing one's license. Each state determines what actions an occupational therapist must take after the practitioner has been away from the field for a certain number of years (AOTA, 2012). In addition to following state guidelines, it is essential for occupational therapists to adhere to the *Occupational Therapy Code of Ethics*. The *Occupational Therapy Code of Ethics* guides occupational therapists in addressing the profession's most prevalent ethical concerns and in making ethical decisions when providing care for patients (AOTA, 2015b).

An occupational therapist who does not meet certain standards of practice or who provides services unethically may be investigated by his or her state's review board to determine if disciplinary action is appropriate. Other professions have conducted studies to evaluate the reasons for disciplinary actions. For example, Ingram, Mohr, Walker, and Mabey (2013) reported that 2,390 disciplinary actions were taken against physical therapists from 2000 to 2009. The three most frequent violations were practicing without a valid license (11.74%); violation of federal or state statutes, regulations, or rules (10.06%); and failure to comply with continuing competency requirements (8.89%). Only 5.5% of these physical therapists had their licenses revoked (Ingram, Mohr, Walker, & Mabey, 2013). Boland-Prom (2009) investigated sanctioned social workers residing in the most populated states between 1999 and 2004. In this 5-year period, 874 social workers were disciplined in 27 states; 23.4% of the disciplinary actions taken were in response to dual relationships and boundary violations (including romantic and non-romantic) and 18.2% were taken in response to license-related problems (Boland-Prom, 2009). As a result, 21% of the sanctioned social workers received a reprimand or a letter of admonishment, whereas 12.1% had their licenses revoked by state licensing boards (Boland-Prom, 2009). Papadakis et al. (2005) concluded that 4% of United States physicians had not met continuing education hours and that 4% had committed sexually related actions; both violations led to disciplinary actions.

The published studies performed on the various professions covered a variety of disciplinary topics, such as fraud, substance abuse, criminal conviction, and failure to comply with professional

requirements (Boland-Prom, 2009; Ingram et al., 2013; Khaliq, Dimassi, Huang, Narine, & Smego, 2005; Sullivan, Bissell, & Leffler, 1990). Fraud refers to a varied category of offenses that involves deception by an individual (Fraud, 2016). In health care, those offenses may come in the form of unnecessary billing for services or items, identity theft, upcoding, unbundling, or kickbacks for patient referrals. Khaliq et al. (2005) found that 7% of physicians in the state of Oklahoma were accused of fraud in 2001. Substance abuse or illegal or unethical drug use in the workplace is unacceptable and can lead to disciplinary actions, such as license suspension or revocation (Sullivan et al., 1990). Drugs, such as narcotics, can be in an occupational therapist's everyday environment, especially if the occupational therapist works in a hospital or home health setting.

Although research has examined the reasons for licensure revocations in other health care professions, we did not identify any literature on occupational therapy license revocations. Knowing the ways in which other practitioners, such as physical therapists and social workers, overstep professional conduct can shed light on possible reasons why occupational therapists violate standards of practice. This study aimed to provide additional insight regarding the reasons for occupational therapy licensure revocations to further educate practitioners in how to maintain licensure by avoiding such behaviors. The knowledge gleaned from this study may provide a better understanding of the reasons occupational therapists have their licenses revoked, while also enhancing professional clinical practice and strengthening ethical standards in occupational therapy educational programs.

Research Questions

1. Which state or region had the most occupational therapy licensure revocations?
2. What was the most common reason for occupational therapists to lose their licenses in different states?
3. Has the most common reason(s) for occupational therapy licensure revocations varied in the last 5 years?
4. What were the characteristic(s) (e.g., years of licensure, gender) of the occupational therapists who lost their licenses?

Method

Study Design

A retrospective descriptive study design (Portney & Watkins, 2009) was used to examine the reasons for occupational therapy licensure revocations in the United States from 2005 to 2015. An evaluation of public data assessed the characteristics of specific groups of occupational therapists who have lost their licenses. Institutional review board (IRB) approval was obtained prior to implementation of this study.

Participants

The participants for this study were occupational therapists in state public disciplinary databases who had their licenses revoked by state occupational therapy licensing boards between 2005 and 2015. We did not collect the names of these occupational therapists. If the database did not provide the information needed for the study, then the researchers contacted the state licensure board representatives through email. Any information provided by a state that met the study's criteria was used in the analyses, even if the state provided only one variable. States were excluded from this study if they did not provide any requested public information in a timely manner.

Data Collection

Following IRB approval, we categorized 50 states into four regions (midwest, west, south, and northeast) based on the United States Census Bureau classification (n.d.); this combined with the absence of the practitioners' names from all records provided anonymity, despite the information being accessible to the public. Public state databases were then accessed and reviewed for the desired variables from 2005 to 2015. The variables included: The occupational therapist's region and gender, the length of licensure before revocation, the revocation year, and the reason for licensure revocation. For states with no data or with insufficient data, a standardized email was sent to the state's disciplinary action representative to obtain information on the desired variables. If a state did not respond after 4 weeks, a reminder email was sent. We omitted states from that data category if the state chose not to participate or release information 2 weeks after the reminder email was sent; these states were listed as "did not respond" in the study records. Any publicly available data was used in the study, despite some missing data related to the variables. If a state with limited or incomplete data did not provide additional data in response to the reminder email, we still used the available data from that state. The collected data from the state licensing board websites or through email correspondence were compiled into a Microsoft Excel spreadsheet and exported for analysis.

Data Analysis

All data analyses were conducted using the IBM Statistical Package for Social Sciences (SPSS) software. Descriptive statistics were used to examine the demographic variables of gender, region, reason for licensure revocation, year of licensure revocation, and length of active licensure. Variables, such as region and year of licensure revocation, were combined during statistical manipulation to increase strength in determining specific characteristics related to reasons for licensure revocations.

Results

Data were obtained from 40 states and the District of Columbia. From 2005 to 2015, 65 occupational therapists had their licenses revoked. The states that did not have public data available online and that subsequently did not respond to emails asking for licensure revocations information were Alabama, Idaho, Illinois, Massachusetts, Mississippi, Nebraska, New Mexico, Ohio, Oregon, and Wyoming.

The majority of the sample was female ($N = 49$, 75.4%), and males comprised 24.6% ($N = 16$) (see Table 1). The northeast region had the lowest number of occupational therapy license revocations ($N = 4$, 6.2%), and the south region had the most revocations ($N = 25$, 38.5%). More occupational therapists lost their licenses in the first 0-10 years of practice ($N = 36$, 55.4%) when compared to occupational therapists who were in the field longer. The year of licensure revocations showed no significant differences among groups.

Table 1

Participant Demographic Characteristics

Variable	N	%
Gender		
Male	16	24.6
Female	49	75.4

Region		
Northeast (CT, MA, ME, NH, NJ, NY, PA, RI, VT)	4	6.2
Midwest (IA, IL, IN, KS, MI, MN, MO, NE, ND, OH, SD, WI)	16	24.6
South (AL, AR, DE, DC, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV)	25	38.5
West (AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY)	20	30.8
Year of licensure revocations		
2005	5	7.7
2006	2	3.1
2007	4	6.2
2008	6	9.2
2009	7	10.8
2010	5	7.7
2011	10	15.4
2012	6	9.2
2013	4	6.2
2014	7	10.8
2015	7	10.8
Unknown	2	3.1
Years licensed in the state		
0-10 years	36	55.4
11-20 years	14	21.5
21 + years	8	12.3
Unknown	7	10.8

The results revealed that occupational therapists had their licenses revoked for a number of reasons (see Tables 2 and 3). The greatest number of occupational therapists had their licenses revoked for fraud (N = 18, 27.7%), followed by criminal conviction (N = 17, 26.2%). Other reasons for occupational therapy licensure revocations included failure to comply with professional requirements (N = 7, 10.8%), unprofessional conduct (N = 10, 15.4%), and personal health (N = 1, 1.5%). Nine occupational therapists (13.8%) had their licenses revoked for multiple reasons. In three cases (4.6%), the reason for revocation was not specified.

Table 2
Reasons for Occupational Therapist Licensure Revocations

Reasons	N	%
Fraud	18	27.7
Criminal conviction	17	26.2
Failure to comply with professional requirements	7	10.8
Unprofessional conduct	10	15.4
Personal health	1	1.5
Multiple of above reasons	9	13.8
Unknown	3	4.6
Total	65	100

Table 3
Reasons for Licensure Revocations Defined

Reason	Description
Fraud	False or inaccurate documentation and billing related to therapy services.
Criminal conviction	The state of being found or proven guilty of a felony charge.
Failure to comply with professional requirements	Failure to comply with state regulations regarding licensure requirements, continuing education, or proper supervision of an occupational therapy assistant or occupational therapy student.
Unprofessional conduct	Unprofessional behavior or failure to report errors in the workplace.
Personal health	Any personal health issue resulting in an inability to competently provide therapy services.
Multiple	Any revocation due to two or more of the described reasons above.
Unknown	The reason for revocation was not stated in public records or in personal communication.

Pearson's Chi-square tests were performed to examine the relationships between the variables. The length of licensure and the reasons for licensure revocations as well as the region and the reasons for licensure revocations were examined. Several significant relationships among these variables emerged ($p < 0.05$). The majority of occupational therapists licensed for 11-20 years had their licenses revoked due to criminal conviction when compared to other reasons ($X^2 = 21.30, p = 0.046$). In addition, most occupational therapists licensed for more than 21 years lost their licenses due to fraud ($X^2 = 21.30, p = 0.046$). Compared to other regions, occupational therapists in the south region received more license revocations because of fraud ($X^2 = 38.58, p = 0.003$). The most common reason for licensure revocations did not significantly change in the last 5 years.

Discussion

The three most common reasons overall for license revocation included fraud, unprofessional conduct, and criminal convictions. Occupational therapists were most likely to have their licenses revoked in the first 10 years of practice; new occupational therapists might engage in these practices because of pressure to pay back loans or because of organizational demands (Weaver, Mathews, &

McGinty, 2015). Therapists in their 11th to 20th year of licensure were most likely to have their licenses revoked because of a criminal conviction instead of fraud. The decrease in rate of fraud may be due to the greater financial stability of this group of occupational therapists. Those who held their licenses for more than 20 years were most likely to receive a revocation because of fraud. Preparing for retirement or productivity standards might be a leading motivator for those occupational therapists. Fraud was the most prevalent cause of revocation in the south region, which might be due to differences in health care culture. Future research should focus on why occupational therapists commit actions that lead to licensure revocations.

No previous studies were conducted regarding occupational therapy licensure revocations. Studies of physical therapy and social work examined disciplinary actions in these professions, but most sanctions did not result in licensure revocations (Boland-Prom, 2009; Ingram et al., 2013). Although these studies did not focus on revocations, the most common violations for physical therapy and social work were fraud, criminal conviction, unprofessional conduct, and failure to comply with professional requirements. These aligned with the reasons for occupational therapy licensure revocations in this study.

Fraud is an important topic in today's health care environment in relation to Medicare and Medicaid payments. It is easier to bill fraudulently than most health care professionals realize. In a study of 31 therapists, 81% admitted to committing Medicare fraud, whether intentionally or inadvertently (Evans & Porche, 2005). More recently, the U.S. Department of Justice obtained 2.5 billion from health care organizations due to fraudulent billing in the fiscal year 2016 (Office of Public Affairs, 2016). Since fraud was the most common cause of occupational therapy licensure revocations, examining the details behind fraudulent billing is critical to reducing the occurrences of fraud in health care settings.

By disclosing the common reasons for occupational therapy licensure revocations, current practitioners can reflect on their own service provision and make changes necessary to ensure licensure maintenance. This study can enhance the education of occupational therapy students by influencing the curriculum at various schools, challenging students to think critically, identifying unethical behaviors, and ensuring students are prepared to make ethical decisions to decrease risk for licensure revocations. Increasing communication among health professionals and analyzing specific patient situations prone to errors can assist occupational therapists in preventing actions that may lead to licensure revocations (Lohman, Scheirton, Mu, Cochran, & Kunzweiler, 2008). Future research could examine the ethics curriculum in occupational therapy programs in the United States, continuing education requirements for current occupational therapists, and occupational therapy disciplinary actions as a whole.

This study had some limitations. The initial emails sent out to states with no licensing information online may have been perceived as spam or junk, which could have affected the overall amount of data collected and email responses received. Furthermore, there was limited generalizability because of a lack of participation from certain states.

There is no standard way for reporting revocations publicly across all states and the District of Columbia. Thus, certain states provided more information than other states. There is also no standardized protocol for determining a sanction versus a revocation. Each state has its own policies when determining and implementing disciplinary actions. In addition, some states had partial information regarding occupational therapy licensure revocations on their public websites. While there are no study limitations, it is important to note that states report and classify disciplinary actions differently.

Conclusion

This study aimed to investigate the reasons why occupational therapists lose their licenses. The highest number of licensure revocations were due to fraud; criminal conviction followed as the second most common reason for revocation. This study revealed that there is no standardized protocol across all states to determine a licensure sanction versus revocation. The results of this study may enhance the education of occupational therapy students and ensure ethical decision-making in practice.

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