

The American Occupational Therapy Association Advisory Opinion for the Ethics Commission

Ethical Issues Around Payment for Services

The Issues

The current health care environment has created the potential for ethical issues regarding payment for occupational therapy services that may have appeared minimal or nonexistent to occupational therapy practitioners before the past 15 years. Central questions include, How do occupational therapy practitioners ethically apply rules for payment? Provide quality care to achieve desired outcomes? Manage resources? Additional concerns may arise from administrative decisions based on maximizing reimbursement (perhaps to offset escalating health care costs) rather than based on clinical judgment. These have the potential to erode trust and respect for the dignity of the client, both of which are the foundation of a therapeutic relationship and place clinicians in a quandary, trying to balance professional ethics with business ethics (Povar et al., 2004).

For example, in the clinical practice arena, payment for services is governed by a variety of federal and private payment guidelines. Clinicians may be confronted with providing treatment to several recipients of service with the same diagnosis but who are “entitled” by differing insurance plans to different levels of care (e.g., number of visits, coverage of equipment/splints, span of treatment) at different levels of reimbursement. For example, some plans provide for a 90% payment and 10% copay by the recipient of service, some plans provide an 80%/20% split, and some have larger out-of-pocket costs. Different insurance plans provide certain levels and types of health care coverage, so in some instances, inevitable differences in care may result in the clinic.

Sometimes, recipients of service are limited to designated facilities because of payer contract restrictions. In some cases, the facilities in the provider network may not necessarily be those best suited by competence of staff and equipment to address their specific medical needs. This raises ethical issues based on the concepts of beneficence, autonomy, and justice. Within the arena of payment for services are ethical concerns about who makes the decisions regarding length and duration of clinical services. Determination of approved services may be done by a third-party case manager without full regard for the complexity of the clinical aspects of a specific case. In the managed care model (including, in many cases, Medicare and Medicaid), the clinical decisions regarding treatment often are made by nonclinical personnel on what may appear to be arbitrary and rigid guidelines (Slater & Kyler, 1999).

For clinical practitioners whose altruism is usually the primary motivating force for seeking a career in occupational therapy and whose guiding principle of ethical practice is *beneficence*, or “doing good” for the recipient of service, these payment and clinical service issues can present frequent dilemmas. At the heart of these dilemmas may be the overriding question of professional autonomy based on who is most competent to direct medical care and the duty to advocate for the good of the patient within the system (Povar et al., 2004). The perception that conflicting motives (business vs. altruism) underlie this decision process has the inevitable

potential to put the occupational therapy practitioner, the employer, and the insurance entity in conflict.

Ethical allocation of finite resources is yet another related and critical issue. Constraints have always existed in health care, as in other aspects of daily life. Material and human resources have never been unlimited. Yet the tremendous advances in medical technology and health care costs over the past few decades have brought the issue of allocating health care resources responsibly and fairly to the forefront (Povar et al., 2004). Managed care and other payer attempts to control spiraling health care costs have resulted in a swing in the pendulum to what many feel are excessive constraints on treatment that could potentially lead to blatant denial of care. Occupational therapists have faced arbitrary discharges or terminations of treatment due to limitations in health insurance coverage. Occupational therapy treatment may be cut short prematurely or never initiated because of policy limits or restrictions in services. However, occupational therapy practitioners have ethical obligations to see that resources are most appropriately allocated according to the principle of distributive justice. The allocation of occupational therapy resources should weigh the skill level of the practitioner, the treatment intensity, the type of intervention needed, and the appropriate timing of that intervention so that consumers can achieve optimal outcome. It is unethical to waste resources.

The prevalence of capitated payment systems in skilled-nursing facilities as well as most traditional medical settings may promote efforts by management to dictate frequency and duration of therapy to ensure maximal reimbursement resulting in pressure on clinicians to comply. If clinicians are not making these decisions based on their professional judgment, resources may be misallocated based on payer source with some patients getting unnecessary therapy and others receiving less benefit. Likewise, in these situations, practitioners may be tempted to modify their documentation of intervention needs to support increased reimbursement, which also is an ethical issue.

Finally, the growth in emerging or nontraditional practice areas (e.g., use of alternative or complementary interventions as an adjunct to more usual occupational therapy practice) presents its own potential ethical issues. In these cases, third-party payment is likely to be very limited or nonexistent. Practitioners need to be clear on whether the services they provide fall within the scope of occupational therapy and legitimately can be billed as such. They also need to understand ethical considerations in developing fee schedules for a client group that may include private payment from individuals as well as by third-party payers. In addition, they need to ensure that their provider contracts do not violate ethical or professional standards.

Discussion

All these issues (e.g., payment rules that may present arbitrary limitations to care, quality of treatment to achieve outcomes, appropriate application of limited resources) can present awkward dilemmas between recipients of services and providers. They also are ethical concerns for clinicians. In this environment, the concepts of beneficence, competence, informed consent, autonomy, and education are paramount. Familiarity with and reference to several documents from the American Occupational Therapy Association (AOTA) can provide a useful framework for making ethical decisions, which are effective in daily practice. In addition, facility-based

ethics committees, supervisors with ethics knowledge, as well as AOTA ethics staff and Ethics Commission (EC) members can assist in analyzing issues and identifying strategies to deal with ethical dilemmas. In many cases, these complex issues do not have clear-cut resolutions, so it is not in the client's best interest for clinicians to attempt to handle them on their own. As stated in Section 10.2 of the *Guidelines to the Occupational Therapy Code of Ethics*, "occupational therapy personnel who are uncertain of whether a specific action would violate the Code have a responsibility to consult with knowledgeable individuals, ethics committees, or other appropriate authorities" (AOTA 2006, in press).

Level of Care and Informed Consent

With respect to loss of autonomy in determining appropriate skill level, treatment intensity, and interventions needed to achieve optimal outcome or the greatest good for recipients of services, both managers and clinicians must rethink service delivery models and educate themselves about cost-effective methods of rendering care. A focus should be on increased collaboration when setting goals with recipients of services so that treatment time is used for the most direct benefit. This is consistent with a client-centered approach to care and with Principle 3A of the *Occupational Therapy Code of Ethics (2005)* (AOTA, 2005), which states that "occupational therapy personnel shall collaborate with recipients, and if they desire, families, significant others, and/or caregivers in setting goals and priorities throughout the intervention process, including full disclosure of the nature, risk, and potential outcomes of any interventions" (p. 640).

The concept of informed consent in any health care environment is particularly important. Clinicians must be able to discuss all treatment options with a patient and significant others so that they can be fully informed and make appropriate decisions about their care. Recommendations for care also must be free from influence by contractual or other arrangements the insurer may have with the provider (Povar et al., 2004). That does not, however, ensure that all interventions will be reimbursed. In some cases, providing services on a pro bono or private-pay basis may be appropriate and viable options to improve access to care. Again, clients must be educated as to risks, benefits, and alternatives in an understandable manner (considering, e.g., language, culture, literacy) so that they can make an informed decision whether to consent or refuse services (Povar et al., 2004).

Section 9.3 of the *Guidelines to the Occupational Therapy Code of Ethics* supports this principle by providing an option for rendering pro bono services with certain parameters: "Occupational therapy practitioners can render *pro bono* (meaning 'for the good' or free of charge) or reduced-fee occupational therapy services for selected individuals only when consistent with guidelines of the business/facility, third-party payer, or government agency" (AOTA 2006, in press, italics added). Although it is not universally possible, within the boundaries of the employer's policy and financial resources, pro bono services can improve access to occupational therapy.

Competence

Practitioner competence is another way to help ensure that, irrespective of external payment limits, treatment sessions are focused on the goals established by the occupational therapy practitioner and the recipient of service. This is addressed directly in Section 4 of the *Guidelines*

to the *Occupational Therapy Code of Ethics* (AOTA 2006, in press): “Occupational therapy personnel are expected to work within their areas of competence and to pursue opportunities to update, increase, and expand their competence.” Regardless of length of treatment, the recipient of service will gain the greatest good through clinicians that are highly competent to provide specific care, thus ensuring that the ethical concept of beneficence is central to the scope of occupational therapy services.

The concepts of *competence* in today’s health care environment are broad. They include not only clinical competence but also knowledge and ongoing education about financial realities and reimbursement/regulatory guidelines, as well as how to meet them. In addition, competence includes an occupational therapy practitioner’s ability to advise recipients of alternative strategies to reach their goals of decreased impairment and increased occupational performance and participation. This is consistent with Principles 4C and 4E of the *Occupational Therapy Code of Ethics* (2005): “Occupational therapy personnel shall take responsibility for maintaining and documenting competence by participating in professional development and educational activities” (AOTA, 2005, p. 640). Also, “occupational therapy personnel shall critically examine available evidence so they may perform their duties on the basis of current information” (p. 640). This will assist occupational therapy practitioners in providing interventions that are most clinically appropriate and effective at the most appropriate point in the continuum of care.

Education and Advocacy

Education and advocacy are additional realms of knowledge that aid occupational therapy practitioners in negotiating the potential minefield of payment guidelines. Section 3.2 in the *Guidelines to the Occupational Therapy Code of Ethics* supports the development of these skills to allow occupational therapy personnel to be “diligent stewards of human, financial, and material resources of their employers” (AOTA 2006, in press). The trust so critical to the therapeutic relationship also includes “a responsibility to practice effective and efficient health care and to use...resources responsibly” (Povar et al., 2004, p. 133). Likewise, it also is a patient’s responsibility to be knowledgeable about and share with his or her therapist the details about his or her insurance plan and reimbursement as it relates to occupational therapy services.

In cases in which there is lack of or limited coverage and the service is essential, there should be a clear and fair procedure for appeal. A clinician’s ability to educate clients on advocacy strategies, rights, and options in the health care system is another way of “doing good” for recipients of services and resolving ethical dilemmas resulting from limitations to care. Advocacy on behalf of clients can include documentation of objective data and relevant evidence to support the positive outcomes of occupational therapy intervention.

It is not unusual for occupational therapy practitioners to treat several clients with the same diagnosis but whom, by virtue of different insurance plans, are entitled to different parameters of care. It is important to remember that recipients of services have chosen a health plan that entitles them to benefits that may not be the same across all payers (Kyler, 1996). It is also important to distinguish between recipients’ perceived right to have services and the obligation of occupational therapy practitioners to their role as an employee of a health care facility to provide more services than are covered. This is not in conflict with the core concept of justice

(AOTA, 1993), which states that we “aspire to provide occupational therapy services for all individuals who are in need of these services” (p. 1086), as these services do not need to be provided in the same way, only in a “goal-directed and objective” manner to the extent possible. However, this situation again emphasizes the importance of occupational therapy practitioners’ competence and presents an opportunity for clinicians to educate recipients of their services about advocacy skills in the greater health care system. It also facilitates a collaborative educational process as occupational therapy practitioners and clients may discuss treatment options, strategies, expected outcomes, and alternative methods of reaching goals.

This collaboration has the potential to make recipients of occupational therapy services more active participants in their own care, thereby increasing the likelihood of a positive outcome. Consistent with Principle 3A of the *Occupational Therapy Code of Ethics (2005)*, “occupational therapy personnel shall collaborate with recipients...in setting goals and priorities throughout the intervention process including full disclosure of the nature, risk, and potential outcomes of any interventions” (AOTA, 2005, p. 640). This principle also is contained within the *Core Values and Attitudes of Occupational Therapy Practice (truth)*, that we be “faithful to facts and reality” (AOTA, 1993, p. 1086). Further, this document states that, despite basic inviolable values, The] degree to which certain values will take priority at a given time is influenced by the specifics of a situation and the environment in which it occurs. The practitioner...is required to engage in thoughtful deliberation to determine where the priority lies in a given situation. (p. 1086)

In sorting through any ethical dilemma presented in practice, the good of the recipient of services must always serve as the focal point from which intervention decisions are made, regardless of ongoing changes in the external environment. Payment regulations may present ethical dilemmas for occupational therapy practitioners. As AOTA members, an important component of our professional role is knowledge about payment guidelines for our services and strategies to assist clients in obtaining beneficial services. The ongoing knowledge base needed to maintain competence in the payment for services area includes financial information from federal and state laws, regulations, and guidelines that cover Medicare and Medicaid payment, as well as private payer sources in both fee-for-service model and managed care models. The occupational therapy role of educator and advocate also must be acknowledged. The concepts of informed decision making by both occupational therapy practitioner and client must be part of the service delivery process.

Conclusion

Guidelines and regulations for payment change. However, the need for current competency in this area does not change. The *Occupational Therapy Code of Ethics (2005)*, *Guidelines to the Occupational Therapy Code of Ethics*, *Core Values and Attitudes of Occupational Therapy Practice*, and other cited documents in this advisory opinion support the knowledge base to provide cost-effective services in an ethical manner. The EC believes that, as members of AOTA, it is incumbent on occupational therapists and occupational therapy assistants to be familiar with these documents and use them in clinical practice.

References

American Occupational Therapy Association. (1993). Core values and attitudes of occupational therapy practice. *American Journal of Occupational Therapy*, 47, 1085–1086.

American Occupational Therapy Association. (2005). Occupational therapy code of ethics (2005). *American Journal of Occupational Therapy*, 59, 639–642.

American Occupational Therapy Association. (in press). Guidelines to the occupational therapy code of ethics. *American Journal of Occupational Therapy*, 60.

Kyler, P. (1996). Ethics in managed care. *OT Week*, 10, 9.

Slater, D. Y., & Kyler, P. L. (1999, June). Management strategies for ethical practice dilemmas. *Administration and Management Special Interest Section Quarterly*, pp. 1–2.

Povar, G. J., Blumen, H., Daniel, J., Daub, S., Evans, L., Holm, R. P., et al. (2004). Ethics in practice: Managed care and the changing health care environment. *Annals of Internal Medicine*, 141, 131–136.

Author

Deborah Y. Slater, MS, OTR/L, FAOTA

Chairperson, Standards and Ethics Commission, 2000–2001

Originally written July 17, 2000

Revised December 2005

Deborah Yarett Slater, MS, OT/L, FAOTA

AOTA Staff Liaison to the Ethics Commission