

**The American Occupational Therapy Association  
Advisory Opinion for the Ethics Commission**

**Ethical Considerations in Private Practice**

**Introduction**

For occupational therapy practitioners with an entrepreneurial spirit and the desire to work independently, a private practice can provide a venue where one can truly reap the benefits of one's work and can provide services consistent with one's interests. For other practitioners the close collaboration with a physician, inherent in providing services "incident to" their practice, is equally appealing.

Occupational therapy practitioners who work in private practice, as either a business owner or employee, must consider a variety of issues to ensure that they maintain an ethical practice. Although practitioners should follow ethical principles regardless of clinical setting, in private practice clinicians are generally more directly involved with and affected by organizational aspects and ethical issues related to business practices. Therefore practitioners, whether owners or employees, need to understand that business stability and predictability of referrals are important; however these must be balanced against their possible influence on clinical care. Whether working in independent practice or in a physician's office, the burden is on practitioners to ensure that they are making clinical decisions that are in compliance with core ethical principles related to benefitting the consumer or patient.

**The Issues**

The key issues related to private practice that may have ethical implications for practitioners include:

1. Referrals
2. Access to Care, Continuity of Care, and Collaboration
3. Practice ownership
4. Documentation and billing

***Referrals***

One of the critical factors in maintaining a viable business is solid and consistent patient referrals, preferably from a variety of sources. Market forces, physician preference, and competition in the community can affect both the number and types of referrals. However, when physicians own a therapy practice some ethical issues can compromise the occupational therapy practitioner. Physicians may selectively refer patients based on their relative economic value. For instance, the physician may refer those patients with "good" insurance to the physician's own therapy practice while referring those patients likely to generate less or no reimbursement to others. Physicians may also refer exclusively to practitioners in their own practice. Although many times this referral is because the physician has confidence in the skills of the occupational therapy practitioner, if it happens regardless of whether the practice or clinician is best qualified to treat that particular patient, then ethical issues can arise. In addition, some physicians may repeatedly refer the same patients for therapy even when those patients do not have significant rehabilitation potential. These situations can create ethical dilemmas for practitioners.

Even with external pressure, practitioners can ensure that they use objective assessments and data to support their clinical decisions about whether a patient can benefit from occupational therapy services and when it is appropriate to discontinue those services. Guidelines 1.6 of *The Guidelines to the Occupational Therapy Code of Ethics* states that “occupational therapy practitioners terminate services when they do not meet the needs and goals of the recipient or when services no longer produce a measurable outcome” (AOTA, 2006, p. 652). Principle I (Beneficence) of the *Occupational Therapy Code of Ethics (2005)* (the Code) also emphasizes the ethical mandate to “do good” or provide benefit to recipients of services (AOTA, 2005). There are effective and ethical strategies to discharge appropriately when they no longer need direct services because their goals are no longer objective and cannot reasonably be achieved in a realistic timeframe or they do not meet reimbursement coverage criteria. The occupational therapy practitioner should consider options such as providing instruction in a home program, training for caregivers, or planning subsequent screening and re-evaluation if the patient’s status changes.

Occupational therapy practitioners in independent practices have the responsibility to ensure that they objectively evaluate and develop plans of care for all patients, including the frequency and duration of intervention. Practitioners have an obligation to be certain that economic gains or a desire to satisfy referral sources do not unduly influence the type and amount of therapy provided. Utilization of services must carefully reflect the clinical status of the patient, collaborative goals, and potential for realistic and meaningful outcomes. Practitioners also have an obligation to be guided by external payer requirements.

### ***Access to Care, Continuity of Care, and Collaboration***

Access to care is an important ethical concept related to social justice. Principle 1C of the Code reminds occupational therapy practitioners of the ethical mandate to “make every effort to advocate for recipients to obtain needed services through available means” (AOTA, 2005, p. 639). There are many issues that can affect access to care, and not all are in the practitioner’s control, such as limited access in rural areas or restricted panels of insurance providers. What is important are the safeguards clinicians must put in place to reinforce that consumers have access to appropriate, qualified providers and have adequate information about what providers are available. Practitioners should always ensure their competence to provide particular services and also provide patients with information about their qualifications. Practitioners can also ensure that their practices or the practices of the physicians from whom they accept referrals have transparent financial relationships, allowing patients to make informed choices about accessing therapy. In all situations, practitioners must consider whether the patient has access to the most clinically appropriate therapy services available.

### ***Practice Ownership***

A key issue with ethical implications that can affect decisions is who owns the practice, and the influences that drives occupational therapy practitioners’ practice patterns in that setting (e.g., payers, referral sources).. In some cases, physicians employ occupational therapy practitioners in their office. The physician can bill and be reimbursed for therapy services provided by the practitioner using the physician’s provider number with Medicare as long as certain requirements are met. In particular, the patient’s course of treatment from that physician must relate to occupational therapy services and the physician must provide direct supervision (i.e., being

present in the office suite). However, when the physician employs an occupational therapy practitioner who is working in his or her office space, he or she will need to be aware of and prepared to address potential issues of undue influence on the duration, type, and frequency of therapy being provided according to Principles 2C and 2D of the Code (AOTA, 2005).

Some of the issues identified in the section on Referrals also apply to private ownership issues. Inappropriate referrals and pressure to over utilize therapy when the patient no longer has viable goals can challenge an independent practitioner who is beholden to comply with a referral source who is also the employer. On the other hand, the convenience of a therapy practice in a physician's office or in the same building can benefit patients, especially older individuals, and potentially facilitate continuity of care. Collaboration and good communication between the physician and occupational therapy practitioner—both keys to good patient outcomes—can occur regardless of location. The same challenges may exist for independent practice owners if they do not want to alienate referral sources that support the financial health of their business. An important way to address this challenge in an ethical manner is transparency: patients must be able to make an informed decision about their options for receiving therapy, which means knowing the qualifications of providers and being aware of any financial gain for either the occupational therapy practitioner or the referring physician that may influence referral recommendations.

Private practice owners must also keep in mind certain applicable state and federal laws related to private practice and potential referral sources. The so-called “Stark” Anti-Kickback laws concerning Medicare and Medicaid and other state laws have specific rules that owners must follow.<sup>1</sup> Penalties for violating these laws can be severe. Practice owners should use legal assistance to ensure compliance with applicable regulations when setting up a business—particularly if a physician or other individual who may have a financial interest is involved.

### ***Documentation and Billing***

Every occupational therapy practitioner has a personal responsibility to be accurate and timely in compliance with documentation and billing standards and regulations, according to Principles 5A, 5E, and 6C of the Code (AOTA, 2005). However, the private practice owner has an additional responsibility to ensure that policies and procedures are in place for enforcing applicable regulations and standards with their employees because the owner is also responsible for the business elements of the organization. Policies and procedures may include regular medical record review or peer review, an in-service on appropriate documentation, timelines for completing documentation, and continuing education on current coding and billing requirements. Proper supervision is particularly critical to prevent situations where an employee leaves the practice, and documentation is incomplete or missing. Without documentation, treatment sessions cannot be billed and reimbursed, and other occupational therapy practitioners who have not treated those patients cannot “fill in” the missing portions of the record. These actions would be potential violations of Principles 5E and 6C of the Code (AOTA, 2005) and Guideline 2.8 of the *Guidelines to the Occupational Therapy Code of Ethics* (AOTA, 2006). The record is a legal document and the information it contains must be accurate. The private practice owner has responsibility for ensuring that employees follow this practice.

## Discussion

A private practice can be rewarding for occupational therapy practitioners who want the freedom to provide clinical services, as they see fit, and who have the requisite business expertise needed to run a viable business. For other practitioners, employment in a physician's office is a better match because they can have the benefits of independence in clinical practice without payment management and personnel issues. However, regardless of the venue, occupational therapy practitioners must address ethical considerations to ensure compliance with professional standards. Practitioners may also face a challenge as to who holds the responsibility to inform consumers about potential ethical issues. These issues can include conflicts of interest related to financial benefit to the referral source or practice owner, as well as the provision for informed consent, and autonomy for consumers in choosing providers when they are referred for therapy. At the American Medical Association's (AMA's) Interim Meeting in November 2008, ethical guidelines on physician self-referral were adopted stating that physicians who refer patients for services at facilities in which they have a financial interest should disclose this interest to patients (O'Reilly, 2008). Further, physicians are advised to avoid any ownership or leasing arrangements that require patient referrals or prohibit recommending competitors. This new policy by the AMA may promote different practices by physicians.

Several principles from the Code (AOTA, 2005) are particularly relevant to the ethical concerns discussed:

- Principle IC: "Occupational therapy personnel shall make every effort to advocate for recipients to obtain needed services through available means" (p. 639). It is the responsibility of occupational therapy practitioners, to the best of their ability, to provide guidance to patients about options for receiving the most appropriate and beneficial therapy from the most appropriate practitioner, regardless of the referral source. The owner of the practice—whether a physician or an occupational therapy practitioner—should not dictate how or where a patient receives therapy. Rather, the occupational therapy plan of care should be based on individual evaluation and clinical needs to maximize patient outcomes, according to Guideline 2.10 (AOTA, 2006).
  - Principle 4H is also relevant and supports the concept of Principle IC: "Occupational therapy personnel shall refer to or consult with other service providers whenever such a referral or consultation would be helpful to the care of the recipient of service. The referral or consultation process shall be done in collaboration with the recipient of service" (p. 640). Communication is crucial to identifying patients' desires and supporting autonomy in their decision making, whether in an occupational therapy practitioner's private practice or a physician's office.
- Principle 2C: "Occupational therapy personnel shall refrain from any undue influences that may compromise provision of service" (p. 640).
  - Principle 6B also supports the concept of Principle 2C: "Occupational therapy personnel shall disclose any professional, personal, financial, business, or volunteer affiliations that may pose a conflict of interest to those with whom they may establish a professional, contractual, or other working relationship" (p. 641). This principle includes the need for practice owners to disclose to patients their ownership of the practice. Ethical principles that focus on benefits to the recipients of services must always guide the practitioner. In addition, practice

owners need to ensure that they do not set up productivity targets and service delivery models geared to maximizing reimbursement without fully considering the impact on individualized and clinically relevant care. Designing programs or approaches to therapy provision intended only to increase profitability is not consistent with the client-centered philosophy of the profession of occupational therapy or with the profession's Ethics Standards. Although economic issues are legitimate considerations, client-centered intervention must remain the central concept and should focus on individualized and meaningful goals to enhance function and participation.

- Principle 2D: "Occupational therapy personnel shall exercise professional judgment and critically analyze directives that could result in potential harm before implementation" (p. 640). This principle may be relevant for occupational therapy practitioners who receive repeated referrals from a particular referrer for patients who cannot benefit from services (e.g., in a physician-owned practice) but have an insurance benefit that will continue to reimburse for therapy.

Several Guidelines (AOTA, 2006) provide additional reinforcement for these concepts:

- Guideline 3.2: "Occupational therapy personnel shall be diligent stewards of human, financial, and material resources of their employers. They shall refrain from exploiting these resources for personal gain" (p. 654).
- Guideline 6.1 and 6.2: These Guidelines relate to "avoidance of real or perceived conflict of interest...to maintaining the integrity of interactions. It is critical to avoid actions which may 'interfere with the exercise of impartial professional judgment during the delivery of occupational therapy services' and ensure that clients are not exploited to further one's 'own personal interests'" (p. 665).
- Guideline 9.5: This guideline mandates that practitioners avoid working for or doing business with organizations that engage in illegal or unethical business practices. This is a professional responsibility whether one is an "owner, stockholder, partner, or employee" (p. 657). Occupational therapy practitioners are also instructed to "refrain from working for or doing business with organizations that engage in illegal or unethical business practices" (p. 657). This means that employees need to exercise due diligence in researching organizations for possible employment opportunities, and must ensure that, after they are employed, the organization continues to follow ethical business practices. Employees need to protect their own license to practice and not get involved by association with illegal or unethical organizations. As business owners, occupational therapy practitioners have a similar responsibility to be aware of and follow applicable laws and ethical guidelines. Business owners should never put their employees in an untenable position of involvement with fraud or questionable service delivery methods as a requirement for ongoing employment.

### **Summary and Conclusions**

Regardless of the practice model, the best interests of the client must be kept at the forefront when providing clinical services. This includes open communication and collaboration among all parties, transparency, and full disclosure to ensure autonomy in patient decision-making, and compliance with applicable laws and ethical principles to meet professional standards.

## References

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

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O'Reilly, K. B. (2008). *AMA meeting: Doctors told to reveal financial stake in referrals*. Retrieved December 8, 2008, from <http://www.ama-assn.org/amednews/2008/12/01/prsf1201.htm>

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<sup>1</sup> It is important to remember that many referral relationships between physicians and therapists are legal. Illegal referral relationships between physicians and therapists are defined as those financial arrangements between the parties that violate state or federal laws. The two major bodies of Federal laws and regulations that identify which types of referral relationships are illegal are the Federal Physician Self-Referral (commonly referred to as “Stark”) and Anti-Kickback laws. The term “Stark Law” commonly refers to Section 1877 of the Social Security Act, which prohibits physicians’ referrals to health care entities with which they (or their immediate family) have financial relationships, for services Medicare or Medicaid might pay. This law was enacted in 1989 and modified in 1993, at which time Congress expanded the list of services to which the law applies to include occupational and physical therapy. The Stark Law has no intent requirement. Therefore, if an arrangement is entered into that implicates the Stark law; the arrangement also must meet an exception to be legal. The Federal Anti-Kickback statute refers to Section 1128 of the Social Security Act, which makes it a crime for anyone to *knowingly and willingly* solicit, receive, offer or pay for any remuneration directly or indirectly (including bribes, rebates, kickbacks, cash or in kind payments) in return for referring an individual for services under any federal health program or in return for purchasing leasing or ordering any good, facility service, or item paid under a federal health care program. The statute specifically exempts certain types of payments and business practices, called “safe harbors,” including compensation paid to bona fide employees.