The American Occupational Therapy Association
Advisory Opinion for the Ethics Commission

Ethical Considerations for Productivity, Billing, and Reimbursement

Background

Productivity is the measurement standard by which most occupational therapy services are quantified and reflects workload expectations of the practice environment. Contemporary occupational therapy practice is influenced by expectations for objective, quantifiable, functional outcomes and also by efforts to generate “units of service” for reporting and reimbursement.

Workload expectations and productivity measurement are legitimate management tools used to ensure appropriate staffing resources for service delivery as well as to maximize reimbursement, with the goal of achieving economic sustainability. Service delivery models, productivity standards, and the practices and methods used to report services for reimbursement must be reasonable and adhere to prevailing ethical and legal standards. The financial interests of the institutional provider and the individual practitioner should not supersede concerns for the client’s own health-related benefit in the planning and provision of occupational therapy.

In today’s environment, health and human services are influenced by complex business models. Labor accounts for a significant percentage of health care costs, so efforts to rein in escalating expenses have emphasized productivity management as an essential tool to positively affect net revenue. However, increasing costs, coupled with diminishing reimbursement and emphasis on efficiency, produce a dynamic challenge for occupational therapy practitioners (Lachman, 2012). In particular, practitioners are challenged to maintain higher caseloads to offset decreased per-client reimbursement yet manage direct and indirect (e.g., documentation) client-related care in less time than previously available, while still meeting quality standards for appropriate clinical services. These challenges are not unique to occupational therapy practice and have been reported by other therapy service providers.

As a result, AOTA, in collaboration with the American Speech–Language–Hearing Association (ASHA) and the American Physical Therapy Association (APTA),
has developed a *Consensus Statement on Clinical Judgement in Health Care Settings* (AOTA, APTA, & ASHA, 2014). The Consensus Statement reinforces the importance of ethical practice, understanding and complying with Medicare and other payer system guidelines, and the need for independent clinical judgment when determining appropriate client care. Resources are also included to guide practitioners in taking action if a problem arises.

The *Occupational Therapy Code of Ethics (2015)* (referred to as the “Code”; American Occupational Therapy Association [AOTA], 2015) reinforces in Principles 4 and 5 that occupational therapy practitioners have an ethical and legal duty to be vigilant in knowing and following the standards and regulations related to clinical documentation to accurately report “treatment time” and bill for their services (see Case Example 1).

**Case Example 1. Juan and Nancy**

Juan, an OT in an outpatient pediatric setting, has learned that a fellow OT, Nancy, routinely treats up to 5 children at a time during a single 1-hour session. For example, she provides treatment for therapeutic activities, neuromuscular reeducation, therapeutic exercise, and ADLs at one time. She subsequently bills and documents for 4 *Current Procedural Terminology*™ (*CPT*) codes (American Medical Association, 2019) per child. This practice means that Nancy is billing for up to 20 units (5 children × 4 *CPT* codes with “per-15 minute” definition) of direct 1-to-1 time during a 1-hour treatment time.

Nancy has justified this practice by stating that she is not reporting her treatment time as “group” treatment but is grouping children appropriately by common treatment needs or goals and that the children are working on individual activities. She has indicated that she sits at a “feeding type” table (children in a half-circle) or “lines them up on therapy balls” while working. She then “sets them each up on exercises” or their handwriting program and divides her time among them to see that they all are staying on track. Juan, however, has worked with several payers in the past and believes that billing for 4 *CPT* codes and 15-minute charge units per child has not taken place, is not an accurate claim request, and does not correctly describe the group procedure performed.

Juan thinks that Nancy’s practice may be an intentional act of deceit for the purpose of receiving greater reimbursement, but he has some doubts and does not want to judge a colleague without knowing all the facts. Juan wonders how best to address this issue with Nancy.
Case Discussion

Once a practitioner has identified an ethical problem or dilemma, a decision-making framework can facilitate his or her analysis of the situation. The process should involve gathering the relevant facts, considering additional information and resources, determining alternatives for action, choosing the best course of action, and evaluating the results of the action or outcome.

Gathering the Relevant Facts. Juan can begin by gathering the facts pertaining to the case. What information does he know, and what additional information might he need? Juan must first be certain about how Nancy’s treatment sessions are being billed, which could include checking charge sheets, if available.

Considering Additional Information and Resources. Juan can refer to the Code to see what principles may apply to billing and reimbursement issues. Veracity, Principle 5C, indicates that occupational therapy practitioners should “record and report in an accurate and timely manner and in accordance with applicable regulations all information related to professional or academic documentation and activities” (AOTA, 2015, p. 6). Likewise, Justice, Principle 4E, directs practitioners to “maintain awareness of current laws and AOTA policies and Official Documents that apply to the profession of occupational therapy” (p. 5). In addition, the principle of Justice, 4K, specifies the obligation to report to appropriate authorities any illegal practice actions or any breaches of the Code.

Most health care payer organizations have formalized and confidential mechanisms to report fraud and abuse pertaining to billing and reimbursement practices. Some have dedicated telephone hotlines for providers to call. However, reporting would be premature until Juan knows all the facts. Juan should continue to gather further information in the organization (Principle 6J; AOTA, 2015, p. 7) before reporting to the payer organization or to state or federal authorities.

It is paramount importance that Juan know the specific rules and regulations that pertain to Nancy’s billing practices before proceeding further. Does the health care organization where Juan is employed have a reimbursement compliance program or compliance officer? If so, Juan could seek further clarification by referring to the health care payer organization’s reimbursement policies and procedures. He could make a fact-finding appointment with the
compliance officer to discuss the situation. There would be no need to disclose the name of the practitioner at this point, and the discussion could occur as a “hypothetical situation.” If, indeed, it was determined that the billing practice was not permissible, Juan would have an obligation to act. If the organization did not have a compliance program or officer, Juan could seek clarification by calling the payer organization’s provider information number. In this scenario, the compliance officer checked the payer policies and procedures and determined that billing for 4 individual CPT codes while providing the treatment in a group setting was not permissible. The plan of care and all documentation and billing records that were obtained did not accurately reflect the services provided and were not in alignment.

Determining Alternatives for Action. After the facts are determined, several options are open to Juan. He could speak directly to Nancy, notify his supervisor, report Nancy to the compliance officer, or report the situation directly to the payer.

Choosing the Best Course of Action. To resolve the ethical problem internally, Juan decided to speak directly to Nancy first as a potential opportunity to educate her. He knows that Principle 7, Fidelity, of the Code highlights the obligation to be faithful and loyal. He feels a sense of loyalty to his colleague as well as to his employer.

Juan first sought to determine Nancy’s knowledge of reimbursement and coding regulations. He found out that only recently has Nancy documented and billed 4 CPT codes when treating 5 clients at a time in a group. Nancy told Juan that she had recently attended a conference during which several other occupational therapy practitioners were discussing billing practices for group treatment sessions. She thought the logic of this approach seemed to be sound and was unaware that it was against payer guidelines. Nancy thanked Juan for informing her of the rules and said she would stop this practice immediately.

Juan felt good about addressing the ethical problem with Nancy and was confident that the unethical and illegal practice would stop. However, after further reflection, Juan was still troubled that their health care organization received fees that were not “commensurate with services delivered” (Justice, Principle 4M; AOTA, 2015, p. 5). Juan spoke again to Nancy about his concern. Both agreed that the overpayment should be returned to the payer. Juan said he would be glad to offer support to Nancy by attending the meeting in which she disclosed the situation to their supervisor. Juan, Nancy, and her supervisor met, and, immediately after the
meeting, the supervisor notified the compliance officer, who notified the payer and returned the funds.

**Evaluating the Results of the Action or Outcome.** Although the reimbursement issue was documented in Nancy’s personnel file, no disciplinary action was taken. Nancy was provided with training to help ensure that she would not make any further inaccurate claim requests and would have the knowledge necessary to use appropriate resources and information to enable compliance.

However, this case could have turned out much differently. If certain leaders in the health care organization had encouraged false billing or a supervisor or compliance officer refused to take appropriate action, Juan would have had to determine what additional action he needed to take. He might have decided to go further up the chain of command in the organization.

If the issue was not addressed internally within the organizational structure, Juan might have had additional options. He might have decided not to work in an environment in which unethical and illegal practices were not addressed. Juan also could have decided to report to external entities, such as the payer organization’s fraud and abuse hotline or state or federal agencies. Doing so might have been the only option he had left to disentangle himself from the unethical and illegal activity.

Juan also could have done nothing. However, doing so could have resulted in moral distress for him and would not have met his ethical obligations. If Juan had gone along with fraudulent billing practices, he could have been subject to payer, state, or federal audits. Consequently, for Juan, these could result in fines, loss of license, loss of employment, and even criminal conviction and incarceration.

Occupational therapy practitioners have an obligation to conform to the productivity standards set by the organization, yet they also have a professional duty to critically examine whether those expectations are congruent with ethical guidelines, legal standards, and requirements of the payer. If these conflict, administrative directives should not take priority over the practitioner’s clinical judgment and the best interests of the client unless legally mandated (Principle 2H). However, efforts to comply with such directives can result in moral distress or ethical dilemmas for occupational therapy practitioners.
Ethical reasoning knowledge and skills can assist practitioners in their professional responsibility to identify, analyze, and take action to resolve ethical dilemmas in these situations.

The Issues

Some of the most frequent questions posed to AOTA by occupational therapy practitioners represent the challenges and dilemmas they encounter in striving to meet employers’ expectations while practicing efficiently, legally, and ethically. Occupational therapy practitioners work in environments in which productivity expectations and business practices often drive service delivery models and daily schedules. Further, current reimbursement models emphasize practitioner productivity along with measurable performance (Gergen Barnett, 2017, as cited in Furniss, 2019). Administrative policies, practice standards, available labor resources, environmental conditions, technology systems, payment sources, and the fluid, real-time decision making for daily scheduling all influence how caseloads are managed and prioritized.

Busby et al. (2015) published a systematic review of literature related to sources of ethical tension in occupational therapy practice. Their findings reinforce that resource and system issues, including conflicting values, discharge planning, decision making, and goal setting, are among the major sources of ethical tension in practice. Emphasis on productivity and measuring performance without considering the demand on providers can lead to burnout (Furniss, 2019).

Ethical challenges related to productivity, billing, and reimbursement may include, but are not limited to,

- Being directed to charge for services not provided, treating clients in groups when reimbursement guidelines do not allow such configurations, or using students or other service extenders to provide “billable” service when not permissible within the applicable regulations (fraud; Principles Veracity and Fidelity);
- Being directed to rate clients’ functional performance as more impaired than is supported by objective data, providing services that are not medically necessary (overtreatment), or coercing participation in services despite the client’s objections (client rights; Principles Autonomy and Nonmaleficence);
• Being required to meet productivity standards that are not realistically achievable in the typical workday; feeling forced to comply with employer directives to “keep the job” rather than “do the right thing”; or deciding whether to report a coworker, manager, or organization when violations are suspected or verified (Principles Fidelity and Justice).

Discussion
All ethical principles of the Occupational Therapy Code of Ethics are applicable to addressing conflicts related to productivity, billing, and reimbursement: Beneficence (Principle 1), Nonmaleficence (Principle 2), Autonomy (Principle 3), Justice (Principle 4), Veracity (Principle 5), and Fidelity (Principle 6).

Administrative Directives
Principle 1A of the Code, Beneficence, describes the duty of an occupational therapist to use evaluation tools that are appropriate to the individual and develop an intervention plan that is specific to the client’s needs (AOTA, 2015, p. 2). Occupational therapy practitioners are trained to use evidence-based tools to assess impairments, occupational performance, and barriers to performance. Practitioners must accurately and truthfully document objective data and develop intervention plans that are reasonable and necessary (Levack, 2009).

Following administrative directives to be “creative” in “finding” goals to keep a client on the caseload or conforming to an administrative override of discharge from services when goals have been met violates the best interest of the client, as outlined in Principle 1H of the Code: “Occupational therapy personnel shall terminate occupational therapy services in collaboration with the service recipient or responsible party when the services are no longer beneficial” (AOTA, 2015, p. 2). Making undue efforts to meet organizational goals for a larger caseload and pursuing profit-based business objectives by inflating the need for or falsely reporting services are all examples of fraudulent behavior. Medicare regulations define fraud as “knowingly submitting or causing to be submitted false claims or making misrepresentation of fact to obtain a Federal Health Care payment.
for which no entitlement would otherwise exist” (Centers for Medicare and Medicaid Services, 2019).

It is incumbent on occupational therapy practitioners to be alert to administrative directives or practices that compromise their ethics or client care and to refuse to participate. It is also critical to remember that all therapy provided must be reasonable, necessary, and skilled and that these principles must guide service provision and billing. To provide guidance to practitioners in understanding and navigating possible ethical conflicts, AOTA (2017) has developed a document listing inappropriate and potentially unethical practices in skilled nursing facilities, *Inappropriate and Potentially Unethical Practices in SNFs.*

Principle 2, Nonmaleficence (do no harm), clarifies that unnecessary treatment may present some risk, with little or no benefit, and also has the potential to harm a client (AOTA, 2015). From a legal perspective, “forcing” participation when a client refuses treatment can be classified as assault and battery. From an ethical perspective, practitioners should also consider the potential harm that may occur when a client has exhausted his or her physical tolerance. Complying with organizational demands to engage clients in treatment while ignoring their capacity to consent or violating their freedom of choice, including their right to refuse services, is not justifiable and clearly violates the clients’ right to autonomous decision making, as noted in Principle 3C of the Code (AOTA, 2015).

Pressure to comply with organizational demands that go against one’s professional ethics can create significant moral distress for practitioners. In a survey conducted by MOT researchers at Brenau University, participants associated the following MDS–R–OT(A) (Moral Distress Scale–Revised–Occupational Therapy Adult Settings) items with the highest levels of moral distress: (1) being expected to obtain as many billable units as possible per client regardless of individual client needs, (2) being unable to provide optimal therapy services to clients because of limited insurance coverage or insurance cutoffs, and (3) being expected to treat and/or write documentation for more clients than time allows. . . . some participants noted being encouraged by management to inappropriately bill for time spent with clients to maximize billable units. (Smith-Gabai et al., 2018, p. 25)

It is vital that practitioners involved in situations or activities that contribute to moral distress take appropriate actions. These actions could include “creating processes for
recognizing that moral distress is occurring, improving team communication, improving the continuity of care, ensuring that employees have the necessary skills to provide appropriate and safe services, and creating and implementing coping strategies” (Smith-Gabai et al., 2018, p. 25).

**Payment Considerations**

Principle 4M, Justice, requires that services may not be delivered and charged inequitably on the basis of payer or reimbursement considerations. When the needs of several clients are equivalent, providing more services to those with the most lucrative reimbursement, to the detriment of those with inadequate funding, is not ethically defensible (Dineen, 2011). In addition, charging different rates on the basis of variable reimbursement potential is not acceptable (Treloar, 2010). Fee schedules must be consistent, regardless of the actual payment, which is based on provider contracts or governmental payment rules.

However, rate consistency does not prohibit “prompt pay” incentives, such as a discount rate if a bill is paid before discharge or within 30 days. These incentives may assist institutions in avoiding further collection costs. Offering these incentives is considered an ethical practice as long as the discounts are offered to everyone and do not discriminate (for more information, see U.S. Department of Health and Human Services, 2008).

The inevitable, intricate relationship between reimbursement and clinical service provision can be difficult to address but must be carefully considered by practitioners. The challenges of reimbursement are accurately reflected in other occupational therapy literature:

> Although payment cannot be the sole consideration when planning occupational therapy evaluation and intervention, our services must fall within the scope of reimbursable services for our clients—otherwise, clients needing occupational therapy services will not be able to obtain them. Providing services that can be afforded only by those wealthy enough to pay out of pocket is discriminatory and will compromise the survival of the profession. (Doucet & Gutman, 2013, p. 8)

Yet this position may present challenges, because occupational therapy practitioners also have a duty to advocate for services that clients need and to seek strategies that enable access to services, especially when traditional reimbursement sources are not an option.
Conversely, situations exist in which practitioners are not limited by constraints of traditional reimbursement. Clients may opt to seek and pay for services for which their health care payer does not reimburse or allow. Health care consumers with financial means have a right to pay for “non-covered” services. Principle 4C, related to Justice, allows that private practitioners may accept cash and permits practitioners to charge for these services on a “sliding scale” as long as a self-pay policy is established and applied consistently.

**Documentation**

Several additional ethical principles provide occupational therapy practitioners with guidance related to reporting services. Principle 5C, Veracity, clearly states that occupational therapy practitioners must “record and report in an accurate and timely manner and in accordance with applicable regulations all information related to professional or academic documentation and activities” (AOTA, 2015, p. 6). Furthermore, as noted in Principle 5B, “occupational therapy personnel shall refrain from using or participating in the use of any form of communication that contains false, fraudulent, deceptive, misleading, or unfair statements or claims” (p. 6). Communications include clinical documentation, charge or billing forms, and written or verbal reporting to clients, coworkers, subordinates, and administrators.

The Principles of Veracity, Justice, and Fidelity also guide occupational therapy practitioners to be truthful by reporting unfair, false, or fraudulent claims for provider reimbursement of services. For example, several components of Principle 4, Justice, and Principle 6, Fidelity, highlight the duty to take appropriate steps to report suspected legal, regulatory, or ethical violations. Practitioners have an ethical obligation to take action when witnessing situations in which false or erroneous documentation or billing occurs. Reporting substantiated concerns to a supervisor or other administrator is an ethical obligation for members of a self-regulating profession.

**Professional Responsibility**

Despite the significant challenges of reimbursement policies, there is no justification for engaging in illegal or unethical behavior while providing, reporting, or billing for
occupational therapy services, even if one’s intentions are good. Occupational therapy practitioners cannot ignore their ethical and professional duty to be informed about billing requirements, nor can they rely solely on others, such as supervisors or administrators, to ensure compliance. Individual practitioners who do not comply with regulatory requirements for reimbursement compromise their legal right to work. Other potential negative consequences for practitioners that may result from unethical practice include criminal charges, professional disciplinary action, and scandal or blemish on their professional reputation.

Although many health care organizations, such as hospitals, rehabilitation centers, long-term care facilities, and home health agencies, have compliance programs and dedicated professionals to keep up-to-date with federal, state, and other requirements, practitioners must verify the source and accuracy of payer processes and administrative directives that affect their practice and payment for services. Certainly the best, first step is to work internally within the formal structure of the organization. If that is not effective, reporting should be considered. A document, *Compliance Reporting*, developed by AOTA, ASHA, APTA, and the National Association for the Support of Long Term Care (n.d.) outlines considerations and steps to take in reporting fraud, abuse, and other non-compliance incidents.

Adverse actions for offending practitioners can include exclusion from participation in federal, state, or private programs that provide reimbursement for services. Consequences may also include termination of employment and loss of right to work if a practitioner’s state license is suspended or revoked. In severe cases, fines are levied, and incarceration can result. In addition, organizations governing occupational therapy practice share information about adverse final actions, so disciplinary action could also be taken by the National Board for Certification in Occupational Therapy® or by the AOTA Ethics Commission if the practitioner is within the jurisdiction of these professional organizations.

Reporting fraudulent or unethical activity requires moral courage and may result in negative professional repercussions or jeopardize one’s professional employment, even when reporting is the right course of action. In an untenable environment, an occupational therapy practitioner may make a decision to leave his or her job, particularly if violations are frequent, violations are not addressed or are not resolved, or the practitioner’s ethical
obligations are constantly challenged. The possible negative consequences for the individual who makes these difficult personal decisions cannot be discounted.

When retaliation is a credible threat, practitioners should investigate whistle-blower protections and mechanisms to report anonymously before taking action. Many organizations have whistle-blower protection programs, as well as policies and procedures to guide employees when they believe they have observed financial improprieties, ethical violations, or other illegal activity. Whistle-blowing takes moral courage as the relator (whistleblower) who seeks to report harmful or illegal actions of their organization may themselves suffer retaliation, marginalization, or even termination from employment while trying to do the right thing (Markkula Center for Applied Ethics at Santa Clara University, 2015), but the long-term yield of doing the right thing should provide enduring relief. In situations in which whistle-blowing results in a finding of fraud, the “relater” (i.e., reporter) may reap a financial reward for assisting in identification of the dishonest conduct.

At the federal level, the False Claims Act (2010) provides the opportunity to redress adverse employment consequences and offers a potential, substantial monetary reward if the proper legal procedures related to whistle-blowing are followed. This law allows a private person to sue a person or company who is knowingly submitting false bills to the federal government. The act also protects qui tam plaintiffs (i.e., whistle-blowers) who are “demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment” (§ 3730[h], [1]) for acts done in furtherance of filing a claim under the act. This provision allows reinstatement; double back pay; interest on back pay; and special damages, such as reimbursement for litigation costs and reasonable attorneys’ fees.

Despite a whistle-blower’s good intentions, the risks associated with reporting must not be minimized. It is essential that the whistle-blower understand the differentiation between legal and illegal practices and gather substantial information and evidence before filing a complaint. Nonetheless, although doing nothing may be an option, practitioners must consider the potential damage to their self-esteem and personal integrity, as well as the moral distress that may result from not taking action and remaining in an adverse and unethical work environment.
**Conclusion**

Productivity demands and reimbursement issues can be sources of tension in the workplace. The realities and challenges of the current clinical service delivery environment do not supersede occupational therapy practitioners’ ethical and legal obligations to be knowledgeable about and compliant with applicable standards and regulations. Occupational therapy practitioners have responsibilities as employees in an organization to meet reasonable productivity requirements and bill for services accurately and appropriately. In addition, practitioners have an overarching ethical duty to advocate for safe, effective, appropriate services for clients.

Discordance between productivity demands and reimbursement issues is an ongoing challenge and may lead to unresolved conflict or provoke ethical angst. Some difficult decisions may be required. When discrepancies and potential violations are identified, occupational therapy practitioners have an ethical responsibility to consider taking action. Ignoring violations is not an appropriate ethical response. Silence is implicit consent, and inaction allows harm to continue.

Using ethical reasoning and accessing the available resources from AOTA and elsewhere (see Exhibit 1) to resolve conflicts can help practitioners meet this professional obligation.

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**Exhibit 1. Resources for Ethical Productivity, Billing, and Reimbursement Practices**

- **U.S. Department of Health and Human Services, Office of Inspector General**
  800-447-8477, TTY: 800-377-4950
- Tips Hotline, PO Box 23489, Washington, DC 20026-3489
  [http://oig.hhs.gov/fraud/docs/advisoryopinions/2008/AdvOpn08-03A.pdf](http://oig.hhs.gov/fraud/docs/advisoryopinions/2008/AdvOpn08-03A.pdf)
- **Centers for Medicare and Medicaid Services**
  800-633-4227, TTY: 877-486-2048
  Medicare Beneficiary Contact Center, PO Box 39, Lawrence, KS 66044
- **Individual insurance carriers, other third-party payers, or health plan sponsors**
  *Note.* Most entities have reimbursement policies and procedures that outline coding methodology, industry-standard reimbursement logic, and regulatory requirements. Inquire directly to the specific company when reimbursement
information or clarification is required. Most policies and procedures can be found on the payer’s website.

- **State agencies regulating the insurance industry**  
  Office of the Insurance Commissioner (Commissioner of Insurance) or (state) Department of Insurance  
  [www.naic.org/state_web_map.htm](http://www.naic.org/state_web_map.htm)

- **State, district, or territorial authority responsible for regulating the occupational therapy profession** (state regulatory board)

- **OT Practice, October, 2018:** “An OT/OTA Team’s Experience Reporting Illegal Skilled Nursing Facility Billing: Relying on Core Values, AOTA, and the OIG to Persevere”  

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**References**


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This ethics advisory opinion has been revised to reflect updated AOTA Official Documents and websites, AOTA style, and additional resources. In January 2019, it was
revised to include updated content by Jan Keith, BA, COTA/L, OTA Representative, Ethics Commission (2017–2020).