The American Occupational Therapy Association Advisory Opinion for the Ethics Commission

Ethical Issues Related to Payment for Service Delivery

Background

The current U.S. health care environment has created the potential for ethical issues regarding payment for occupational therapy services that may have been minimal or nonexistent for occupational therapy practitioners before now. The inception of accountable care organizations (ACOs) and alternative payment models that are still evolving, as well as the shift toward increased emphasis on outcomes and value-based care, has increased the potential for these ethical challenges.

Occupational therapy practitioners can add value as an integrated service within ACOs, to assist them in meeting quality measures and "demonstrate how current best practice aligns with the goals of an ACO without the need for drastic changes to the payment model" (Miller, 2018, p. 3). Central questions include:

- How do practitioners ethically apply rules for payment?
- How do practitioners provide quality care to achieve desired outcomes?
- How do practitioners effectively and ethically 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.

The business orientation of health care organizations can prioritize "system efficiencies and outcomes over service recipients" (Gupta & Taff, 2015, p. 247; Mackey, 2014). This also presents challenges to client-centered care, which is a philosophical basis of occupational therapy and can have a negative impact on the relationship between therapist and client. The therapeutic relationship is based on trust between therapist and client, and client-centered therapy is focused on dignity, respect, and empowerment (Gupta & Taff, 2015).

In clinical practice, a variety of governmental and private payment guidelines regulate payment for services, which often dictates care. Clinicians providing treatment to multiple service recipients with the same diagnosis may find that payers authorize different benefits (e.g., frequency and duration of treatment, treatment settings, coverage of orthotics). Non-clinical personnel often make these clinical decisions, thus superseding the practitioner's judgment and impacting their ability to meet patient goals (Gupta & Taff, 2015). 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 in terms of staff competence, specialization, and equipment to address their specific medical needs. These issues raise ethical concerns based on the concepts of *Beneficence, Autonomy, and Justice*.

Organizational Considerations, Clinical Judgment, and Resource Allocation

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, reimbursement and clinical service issues frequently can present dilemmas. At the heart of these may be the overriding question of professional autonomy, which supports the freedom of the practitioner to act without constraints, according to their best judgment on behalf of patients (Doherty & Purtilo, 2016). The perception that conflicting motives (business vs. altruism) underlie this decision process has the potential to put practitioners, employers, and insurance entities in conflict.

Ethical allocation of finite resources is another related, critical issue. Constraints have always existed in health care; fiscal 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). In addition, concerns are being raised about how to address competing health care needs across populations and constituencies, given the shifting demographics (Doherty & Purtilo, 2016, p. 424).

Differing approaches and viewpoints are related to what principles should guide resource allocation. Organizational attempts to control spiraling health care costs have resulted in a swing of the pendulum to what many feel are excessive constraints on treatment that could potentially lead to reductions in or blatant denial of care. Limitations in insurance coverage may result in arbitrary discharge or abrupt termination of occupational therapy services. Occupational therapy treatment may be cut short prematurely or never initiated because of policy limits or restrictions in services.

However, occupational therapy practitioners have an ethical obligation to see that resources are most appropriately allocated according to the Principle of Distributive Justice. The allocation of occupational therapy resources should consider practitioner skill level, type of intervention needed and treatment intensity, and appropriate timing of the intervention along the continuum of care so that consumers can achieve optimal outcomes. It is unethical to waste resources.

In addition to payer directives, administrative directives can also dictate type, frequency, and duration of therapy with excessive productivity requirements to ensure maximal reimbursement. This can result in ethical distress. If clinicians are not allowed to make these decisions according to their professional judgment, resources may be misallocated on the basis of payer source, with some patients receiving unnecessary therapy and others less. Likewise, in these situations, practitioners may be tempted to modify their documentation of the client's need for services 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 and customary occupational therapy practice) presents its own potential ethical issues. In these cases, third-party payment is likely to be limited or nonexistent. Practitioners need to be clear about 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 reimbursement 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 can present challenging dilemmas for providers in their dealings with recipients of services. They can also present ethical concerns for clinicians. In this environment, beneficence, competence, 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 that are effective in daily practice. In addition, facility-based ethics committees, supervisors with ethics knowledge, and AOTA ethics staff and Ethics Commission (EC) members can assist practitioners and their managers 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.

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 re-think service delivery models and educate themselves about cost-effective methods of rendering care. The Patient Protection and Affordable Care Act (ACA; P. L. 111–148), enacted in 2010, while targeting the Medicare program to decrease spending and increase efficiency, quality, and coordination of care, nevertheless will affect broader health care policy and occupational therapy services (Fischer & Friesema, 2013). Links between performance/outcomes and payment provide opportunities for occupational therapy practitioners to utilize evidence-based guidelines, client-

centered care, and validated assessments that are considered best practice to benefit both their organizations and recipients of services (Fischer & Friesema, 2013). A focus should be on increased collaboration when setting goals with recipients of services so that physical and cognitive therapeutic activities are carefully selected to provide functional capacity for the most direct benefit (Fischer & Friesema, 2013). This is consistent with a client-centered approach to care and with Principles 3B and 3D of the Code, which state that
Occupational therapy personnel shall:

- "Fully disclose the benefits, risks, and potential outcomes of any intervention; the personnel who will be providing the interventions; and any reasonable alternatives to the proposed intervention" (AOTA, 2015a, p. 4); and
- "Establish a collaborative relationship with the recipients of service and relevant stakeholders to promote shared decision making" (p. 4).

Clinicians must be able to discuss all treatment options with a client 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 an appropriate and viable option 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 to or refuse services (AOTA, 2015a).

Principle 4C of the Code supports this concept by providing an option for rendering pro bono services with certain parameters: "Occupational therapy personnel shall address barriers in access to occupational therapy services by offering or referring clients to financial aid, charity care, or pro bono services within the parameters of organizational policies" (AOTA, 2015a, p. 5). Although it is not universally possible within the boundaries of employers' 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, interventions are focused on the goals established by the occupational therapy practitioner and the recipient of service. This issue is addressed directly in Principle 1G of the Code: "Occupational therapy personnel shall maintain competency by ongoing participation in education relevant to one's practice area" (AOTA, 2015a, p. 3).

Regardless of length of intervention, the recipient of service will gain the greatest good through clinicians who 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 concept of *competence* in today's health care environment is broad. Competence includes not only clinical competence but also knowledge and ongoing education about financial realities and compliance with reimbursement and regulatory guidelines. 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 (AOTA, 2015b). This is consistent with Principle 1E of the Code: "Occupational therapy personnel shall provide occupational therapy services, including education and training, that are within each practitioner's level of competence and scope of practice" (AOTA, 2015a, p. 3).

Likewise, according to Principle 1C, "occupational therapy personnel shall use, to the extent possible, evaluation, planning, intervention techniques, assessments, and therapeutic equipment that are evidence-based, current, and within the recognized scope of occupational therapy practice" (AOTA, 2015a, p. 2). Upholding this principle will assist occupational therapy practitioners in providing interventions that are clinically targeted 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 for services. Principle 6E of the Code supports the development of

skills to allow occupational therapy personnel to “be diligent stewards of human, financial, and material resources of their employers” (AOTA, 2015a, p. 7). As previously noted, resources can be limited while need is not, making decisions about how best to ration an ethical challenge (Scheunemann & White, 2011). Further, it also is a client’s responsibility to be knowledgeable about and share with his or her therapist the details about his or her insurance plan and reimbursement as related to occupational therapy services.

Coverage for occupational therapy services can differ widely depending on the client’s insurance plan. 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 educating 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 also important to distinguish between recipients’ perceived right to obtain services and the obligation of practitioners in their role as an employee of a health care facility to provide more services than are covered.

According to Principle 4B, occupational therapy practitioners should “assist those in need of occupational therapy services to secure access through available means” (AOTA, 2015a, p. 5). Services do not need to be provided in the same way, only in a goal-directed and objective manner to the extent possible. This situation 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 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, and is consistent with the collaborative relationship called for in Principle 3D of the Code and within the Core Value of Truth, which infers that prioritizing values is also done through thoughtful deliberation.

Conclusion

Looking ahead, the health care system in the United States will likely continue to evolve. Although guidelines and regulations for payment change, the need for occupational therapy practitioners and managers to have competence in areas related to service delivery does not. The Code of Ethics and other resources cited in this Advisory Opinion support the knowledge base to provide cost-effective services ethically. Practitioners must be familiar with these documents and use them in clinical practice.

In sorting through any ethical dilemma presented in occupational therapy practice, the good of the client must always serve as the focal point from which intervention decisions are made, regardless of ongoing changes in the external environment. An important component of the occupational therapy professional role is having knowledge about payment and strategies to assist clients in obtaining beneficial services. The ongoing knowledge base needed to maintain competence in this area includes financial information from federal and state laws, regulations, and guidelines that cover Medicare and Medicaid payment and private payer sources in both fee-for-service and global payment models. The 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.

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Deborah Y. Slater, OT, MS, FAOTA
Consultant, Ethics Program, American Occupational Therapy Association

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