Reimbursement for Psychiatric Occupational Therapy Services

(insurance coverage, mental health treatment, third party payers)

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It is increasingly important for mental health occupational therapists to monitor trends in reimbursement for mental health care in order to ensure adequate and equitable coverage of occupational therapy services. Federal and state funds for treatment of mental illness are being divided among an increasing number of mental health professionals. Private insurers are limiting direct coverage to those services that can supply cost and utilization information. This paper reviews present coverage for occupational therapy in mental health programs. Collection of efficacy and cost benefit data, establishment of separate billing procedures, and participation in the formation of public policies for treatment of the mentally ill should be primary activities pursued by occupational therapists to expand coverage of occupational therapy services in psychiatric settings.

Adequate development of third party insurance coverage for treatment of the mentally ill has been plagued by the lack of uniform evaluation tools, vague diagnoses, unmeasurable treatment concepts, and lack of efficacy and cost studies demonstrating the benefit of treatment methods. Some historical information may provide insight into the problems of insurance coverage for mental illness and assist in formulating strategies for developing more adequate and equitable coverage for occupational therapy services.

Fifty years ago, health insurance programs were limited to inpatient hospital medical and surgical conditions. Outpatient coverage was either nonexistent or offered only for medical care provided in doctors' offices or emergency rooms. Treatment for mental illness was provided on a long-term basis in state and county hospitals, and in some private hospitals. Since care for mental illness was financed primarily by state institutions, private insurance for treatment of mental conditions was not offered (1).

After World War II, treatment settings for psychiatric conditions expanded. Some general hospitals began establishing small psychiatric units, and private insurers began to provide coverage to office-based physicians specializing in psychiatry. Commercial insurance, which usually covered any treatment in a general hospital, expanded coverage to include treatment for mental conditions (1).

In the 1950s, major medical insurance was offered for outpatient medical and surgical treatment. During this time, coverage for treatment of outpatient mental conditions was expanded. In some plans, coverage of psychiatric treatment was equal to the coverage for medical and surgical benefits. Expanded treatment for psychiatric illness only included psychoanalysis, and reimbursement for mental health treatment continued to be limited to physicians' services. It quickly became evident to insurers that psychoanalysis was a difficult and costly treatment to provide through insurance. Treatment was not measurable, and cost benefit studies were difficult to undertake. Patients did not appear disabled, and treatment often continued for an indefinite period of time. Based on these problems, insurance companies began to reduce benefits for outpatient psychiatric treatment (1).

During the 1960s and 1970s, a combination of changing public policy and scientific advances in psychotropic medications shifted treatment of the mentally ill from institutions to the community. These developments made it possi-
sible for chronically ill individuals to avoid long-term hospitalization and to receive treatment in the community. To accommodate the changes in policy and treatment philosophy, federal, state, commercial, and private programs expanded coverage of mental illness to outpatient settings and facilities. Despite these changes, few of the new mental health benefits included an expansion of providers of mental health treatment (1).

Today, health insurance coverage for mental illness continues to be provided through federal, state, private, and commercial sources; however, plan benefits are limited, and services offered are rarely equal to insurance coverage for medical and surgical treatment.

Coverage of occupational therapy services is not uniform throughout mental health programs that are covered by third party payers, and reimbursement for occupational therapy is often inconsistent and vague. Present reimbursement for occupational therapy mental health services under federal, state, and private health programs is described below. A discussion of the problems affecting the reimbursement status of occupational therapy services in mental health follows.

Federal Reimbursement

Medicare Part A (Title XVIII, Social Security Act). Under the Medicare Part A program, mental health treatment is only covered on an inpatient hospital basis. Medicare payment for inpatient psychiatric services is limited to 190 days of inpatient care during the life of the beneficiary. To qualify for Medicare Part A coverage of psychiatric services, the beneficiary must be an inpatient of a participating psychiatric hospital or participating general hospital with psychiatric beds, and have a diagnosis of "mental illness" as described by specific psychiatric conditions in the Diagnostic and Statistical Manual of Mental Disorders (DSMIII) (2).

Hospitals must meet certain conditions to qualify for reimbursement for Medicare patients. The conditions for general hospitals with psychiatric beds and psychiatric hospitals are designed to ensure that the program provides reimbursement for active treatment, while avoiding payment for care that is custodial. Occupational therapy is specifically included in the conditions of participation for general hospitals, psychiatric hospitals, and general hospitals with psychiatric beds. The standard states that "... Qualified therapists... are sufficient in number to provide comprehensive therapeutic activities, including at least occupational, recreational, and physical therapy... to assure that appropriate treatment is rendered for each patient and to establish and maintain a therapeutic milieu." (3, p 303). Other services included in the conditions of participation under the Medicare Part A mental health benefit include psychology, nursing, social work, and physicians' services.

Psychiatric hospitals and psychiatric units of general hospitals are exempt from the Medicare Prospective Payment System, which was implemented October 1, 1983, and they are receiving reimbursement on a reasonable cost basis. However, by December 31, 1985, the U.S. Department of Health and Human Services must submit a plan by which psychiatric inpatient services could be included in the prospective payment system. At that time, providers may receive reimbursement on a case-by-case basis for psychiatric patients.

Medicare Part B. Payment for outpatient psychiatric services under the Medicare Supplemental Insurance (SMI) program is particularly limited. A 50-50 copayment ratio is applied, and Medicare will only pay 50 percent of the cost of mental health services up to a maximum of $250 per year.

Unless the services are provided in a Comprehensive Outpatient Rehabilitation Facility (CORF), physicians may only receive reimbursement under the SMI program for psychiatric services. Physician services may be furnished in a community mental health center, an outpatient department, in the office, or in the patient's home, as long as the patient is not an inpatient of a hospital.

In December 1982, regulations implementing CORFs were made final, establishing CORFs as the only setting in which mental health services can be provided under the Medicare Part B program by non-physician health professionals (4). Occupational therapy services, if furnished to a CORF patient with a psychiatric diagnosis, are reimbursable up to the $250 maximum limit provided under the Medicare Part B mental health program. However, the limit applies to the total CORF services provided; that is, charges for physician, occupational therapist, and any other services provided to a psychiatric patient may not exceed $250.

Medicaid. Medicaid (Title XIX of the Social Security Act) is a federally aided, state-administered program of medical assistance to persons with low income whose resources are insufficient to meet the cost of necessary medical services. To receive federal Medicaid funds, a state Medicaid plan must
provide certain services such as inpatient and outpatient hospital care, clinic services, and skilled nursing facility services. When state plan requirements are met, a state may also provide optional services that are included in the Medicaid law. Occupational therapy is included as an optional service under the Medicaid program. Mental health services are provided to Medicaid beneficiaries in hospitals, clinics, physicians' offices, and community mental health centers, and, unlike Medicare Part B, there are no limitations with respect to physician or nonphysician services provided in outpatient settings.

Medicaid state plan requirements must include inpatient psychiatric services in institutions for individuals less than 21 years of age and in mental institutions for individuals more than 65. In facilities providing Medicaid mental health services for individuals less than 21 years old, occupational therapy is specifically included as an optional service that may be provided in a state Medicaid plan. The law states that “an individual plan of care must be developed by an interdisciplinary team of physicians and other personnel who are employed by or provide services in the facility” (5, p 674). The team must include one of the following: (a) a psychiatric social worker; (b) a registered nurse with training in psychiatric services; (c) a psychologist with a master's degree or certification by the state; or (d) an occupational therapist who has specialized training or one year's experience in the treatment of mentally ill individuals (6).

State plan requirements for institutions for persons more than 65 years old are less specific concerning the services that must be provided to qualify for federal funds. The requirements include: (a) certification by a physician that inpatient services in a mental hospital are needed; (b) a medical, psychiatric, and social evaluation; and (c) an individual written plan of care, which must include “rehabilitative and rehabilitation” services such as activities, therapies, social services, and diet (7).

A state must also provide in its Medicaid mental health plan an alternative comprehensive mental health program that includes services provided in noninstitutional settings. The outpatient program must use mental health and public welfare resources including Community Mental Health Centers (CMHCs), clinics, outpatient hospitals, and other alternatives to public institutional care. Occupational therapy may be provided as a mental health service under a state's Medicaid plan in these settings if the state opts to include occupational therapy services.

CHAMPUS. Civilian Health and Medical Plan of the Uniformed Services (CHAMPUS) is a health care program for dependents of armed services active duty members and for retired members of the armed services, and shares the cost of health care received from civilian sources.

The inpatient mental health care benefit is limited to 60 days a year. Occupational therapy services are included when it is part of a physician prescribed inpatient treatment program. Occupational therapy is specifically excluded from coverage when provided in outpatient settings.

Federal Employees Health Benefits Program. The Federal Employees Health Benefit Program is the largest health insurance program in the country and provides coverage for 9.2 million individuals. Under current law, the government's share of the cost of an enrollment equals 60 percent of the average high option premium of six representative plans. This amount is contributed to the total cost of enrollment by the government, and the enrollee pays the remainder. The United States Office of Personnel Management administers the program and serves as a broker for rates and benefits between federal employees and private insurance plans such as Blue Cross/Blue Shield, Aetna, and Health Maintenance Organizations (HMOs). Federal law and regulations governing the scope of services that must be provided by these plans do not specify services to be covered except that participating plans must include surgical and medical services.

The coverage of mental and nervous disorders, including specific services, settings covered, and other coverage requirements, are developed by each private health plan participating in the federal program. Most of the plans impose conditions and limitations on major medical and supplementary medical (outpatient) coverage for mental health benefits.

In most of the plans, major medical benefits for treatment of mental and nervous conditions provided as a hospital inpatient benefit or outside of a hospital are subject to limitations and copayments. The limitations range from 30 to 90 days of inpatient care. Copayments are required on outpatient services ranging from $20 to $50 a visit.

As mentioned earlier, the plans are not bound to provide specific services under the mental health benefit. All of the plans reviewed...
include major medical benefits for
treatment of mental and nervous
conditions, but the plans vary ac-
cording to limitations, copay-
ments, and covered services. In
most of the plans, covered services
include individual and group
therapy; collateral visits with mem-
ers of the patient's family pro-
vided by a doctor; clinical psychol-
ogist, psychiatric nurse, or licensed
psychiatric social worker; day-
night psychiatric services rendered
on an "other-than-inpatient" basis
in a hospital-licensed mental
health facility; and psychological
testing or evaluation. None of the
plans specifically include occupa-
tional therapy in covered services
for mental and nervous disorders.
However, when occupational
therapy is included as a covered
major medical service, it is often
included in inpatient-covered psy-
chiatric services. Occupational
therapists may consult the specific
plan for coverage requirements of
psychiatric occupational therapy.

State Reimbursement
Mandatory Commercial Coverage. Mandatory insurance coverage is
achieved through state regulation
of minimum benefits in all com-
cmercial insurance policies. The
mandated benefits may include
specific types of treatment, the ex-
tent of coverage for treatment, set-
tings in which the treatment may
be provided, and the professionals
who may be reimbursed for pro-
viding the treatment (8).

Efforts to improve coverage of
mental health treatment through
mandatory insurance legislation
are being sponsored by social
workers, psychologists, and nurse
practitioners. These proposals
concern mandated minimum ben-
fit packages and freedom of
choice laws, which would make
certain professionals eligible for
reimbursement. At the present
time, there are 14 states with laws
mandating mental health benefits
including specific providers (9). For
example, in 1982, the Maine
legislature enacted health insur-
ance legislation that included a
mandated benefit package (10). The
law requires all health insur-
ance policies to include specified
benefits for mental health, alcohol,
and drug treatment. The law also
includes language authorizing in-
surance reimbursement for psy-
chologists, social workers, and
nurse practitioners when pro-
viding services described in the
mandated benefit package. Occupa-
tional therapy has not been spe-
cifically included in the mandatory
insurance legislation. Occupa-
tional therapy services may be in-
directly included by provisions de-
scribing extent of treatment ben-
fits or settings in which treatment
is provided. Specific information
may be gained by obtaining a copy
of the particular state law man-
dating the benefits.

State Facilities. State facilities
providing occupational therapy
services for psychiatric patients
may include community mental
health centers, state hospitals, and
partial hospitalization and day-
care centers. The state health or
mental health budget is a combi-
nation of Medicaid, federal block
grants, and funds appropriated by
the legislature for operating and
providing mental health services
within these facilities. Usually a
state agency, such as the health de-
partment or department of mental
health, allocates the funds from
the budget for specific facilities
based on factors such as size, num-
ber of residents, geographical
location, purpose of facility, and
type of treatment offered. Within
individual facilities, administra-
tors, financial officers, or depart-
ment heads determine budgets for
specific services. Depending on
the state system and budget pro-
cess of individual facilities, occu-
pational therapy services may be a
part of activity therapy or may be
an individual line item in the fa-
cility budget.

These differences in funding for
state occupational therapy ser-
VICES can vary from facility to fa-
cility and from state to state. To
determine the specific source of
state reimbursement for occupa-
tional therapy services, it is impor-
tant to investigate facility budgets
as well as the allocation process for
state health or mental health
funding.

Community Mental Health Centers. Community mental health centers
(CMHCs) are not recognized as
providers of care by Medicare.
They are, however, funded by a
combination of federal, state, and
private sources to provide a variety
of services to acute and chronically
ill individuals. Although 50 per-
cent of funding is under state
mental health budgets, community
mental health centers' services are
also provided through federal
block grants and Medicaid. Private
or commercial insurance plans
may also provide reimbursement
for services within a community
mental health center setting.
Funds for operating the commu-
nity mental health center and
funds for reimbursement for ser-
VICES may often come from dif-
ferent sources.

Occupational therapists work
within a multidisciplinary team
in CMHCs, which include psy-
chiatrists, psychologists, social
workers, and nurse practitioners.
As discussed earlier, physicians are
providers under the Medicare Part
B mental health benefit, and therefore are directly reimbursed in outpatient settings by Medicare for their services. The services of other professionals, such as occupational therapists, are provided through a combination of state appropriations, Medicaid, and commercial insurance funds that are designated for other therapy programs within the CMHC setting.

Private Reimbursement

Among commercial health insurers, extensive coverage of health and medical expenses can be found. The plans are offered through employers, HMOs, and employee benefits plans. Mental health benefits vary widely from plan to plan. To determine specific benefits or coverage of occupational therapy, review each commercial health plan.

In general, when psychiatric occupational therapy services are not included in private or commercial plans, they may be indirectly paid for under a room rate per diem on a hospital inpatient basis. Private psychiatric hospitals and general hospitals with psychiatric units usually include other costs in the regular “room and board” charges. These costs are referred to as program service costs and cover certain nonmedical or other services required by accreditors such as the Joint Commission on Accreditation of Hospitals (JCAH), but not directly reimbursed by private or commercial insurers. Occupational therapy may be included in these settings under the title of Activity Therapy or under a separate category within the room rate per diem.

Discussion

Three issues associated with increasing reimbursement for occupational therapy services in mental health settings are:

1. Collection of data to establish the efficacy of mental health care and the cost of providing specific services such as occupational therapy.
2. Administrative and organizational arrangements that provide occupational therapy and other services under the umbrella of “activity departments”; and
3. Inclusion of occupational therapy with other disciplines in legislation that establishes occupational therapists as providers of care in federal and state mental health programs.

To increase the coverage of occupational therapy in mental health insurance programs, more data concerning the effectiveness and the cost of occupational therapy treatment provided in health care settings are needed. Health insurers and others must make difficult decisions related to the types of services and service providers that should be covered in mental health programs. These decisions are increasingly based on the frequency of use of the service, benefit of particular treatment methods, and the cost of providing the treatment. Concrete data presented to show the benefits and cost of providing occupational therapy services substantiate requests by beneficiaries and providers for coverage in insurance policies.

Collecting efficacy and cost benefit information consists of designing studies to answer statistically questions, such as the following, that prospective third party payers of occupational therapy psychiatric services would pose:

1. What treatment techniques are being used?
2. What is the outcome of that treatment?
3. How often is the treatment used?
4. What is the cost of providing that treatment?

For example, evaluation and treatment techniques that address job skills, interpersonal skills, and other aspects of self-care should be included in studies to provide statistical answers to third party payer questions such as these.

To design such studies is difficult. Due to the variety of health care systems in which care for psychiatric illness is provided, few evaluation and treatment methods are quantifiable. As with other disciplines in mental health, there are variations in occupational therapy procedures not only from therapist to therapist, but from client to client and from setting to setting. The task of documenting the efficacy and costs of occupational therapy treatment methods as shown by Linn et al. (11) must continue to be addressed if occupational therapy is to be included as a mental health benefit in all insurance plans and policies.

Reimbursement problems for psychiatric occupational therapists are often reinforced when occupational therapy is provided through activity therapy departments. The JCAH Consolidated Standards Manual defines Activity Services as “... the principles and practices of art, dance, movement, music, occupational therapy, recreational therapy, and many other disciplines” (12, p 125). This arrangement promotes role blurring, and it becomes difficult to track the number of treatments and type of treatments provided by occupational therapists. Furthermore, when claims are submitted to insurers for services...
performed by occupational therapists, revenue is not credited to occupational therapy, but to activity therapy.

Today in mental health settings the increasingly autonomous and therapeutic role of occupational therapists blends with other disciplines who provide similar and occasionally the same services, such as social workers, nurses, and psychologists. The services provided by mental health occupational therapists are distinct from other therapies and can be differentiated from activity therapies to improve reimbursement status. We may improve our reimbursement status in many federal, state, and private mental health programs. To improve our present reimbursement status in mental health, occupational therapists can collect information demonstrating efficacy and cost benefits of providing services in psychiatric settings. Methods distinguishing occupational therapy from other activities must be established so that the costs and services of occupational therapists may be more clearly defined.

Participation in the political process to support mental health legislation can improve coverage of occupational therapy services in settings for the mentally ill. As health care costs rise and funds for programs diminish, occupational therapists will need to determine the billing methods for services and to establish statistical data supporting coverage for occupational therapy in mental health.

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