Many local education agencies across the United States have implemented a billing structure for school-based occupational therapy services that accesses Medicaid dollars. This structure was made possible through a series of amendments to the Medicaid Program: (1) Title XIX of the Social Security Act (Public Law 89–97), (2) Medicare Catastrophic Coverage Act of 1988 (Public Law 100–360), and (3) the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203). These amendments gave school administrators the authority to bill Medicaid for “related services” provided to school children with disabilities who met financial eligibility. Related services, as defined in the Education for All Handicapped Children Act of 1975 (EHA; Public Law 94–142), are those services, such as occupational therapy and physical therapy, provided to students with disabilities that permit them to benefit from special education within the least restrictive education environment.

The intent of the Title XIX amendment was to allow expensive equipment, such as technologically advanced wheelchairs that would help a special education student function within the education setting, to be funded through Medicaid. In actuality, however, Medicaid began to be billed not only for technology equipment for students, a medically related service, but also for all school-based occupational therapy services, regardless of whether the service was educationally or medically related.

There is a difference between medically and educationally related occupational therapy services. Medically related services focus primarily on the individual student, whereas educationally related services focus on parent and teacher concerns and student interactions within the specific education setting. When using the medical model, evaluation of a student relies on standardized tests to identify underlying physical problems, which may or may not be related to the student’s educational performance in the classroom. When using the education model, evaluation focuses on the student’s educational performance within the classroom or education setting, using expert observation (American Occupational Therapy Association [AOTA], 1997). Other distinctions between these two types of related services are shown in Table 1.

The need to distinguish educationally related occupational therapy services from medically related occupational therapy services was an outcome of the EHA and its stress on an educational context for the delivery of related services. The EHA was amended by the Individuals With Disabilities Education Act of 1990 (IDEA; Public Law 101–476) and reauthorized in 1997 (Public Law 105–17). This reauthorization continues to assure that children and young adults with disabilities, 3 to 21 years of age, are entitled to a free, appropriate public education. This legislation also continues to ensure the place of occupational therapy as a related service in special education.
The practice of billing Medicaid for occupational therapy services in the school is required by EHA. Because Medicaid, now a major reimbursor for school-based services, is predicated on a medical model that is not in accord with providing the educationally related services mandated by the IDEA, we were concerned that occupational therapists may be making decisions about services that are driven by resources rather than by the student’s needs. Therefore, we conducted a pilot study of the effects on practice of billing Medicaid for school-based occupational therapy services.

Understanding the influence of a payment system on practice will help us to assure quality of services. Understanding the influence of a payment system that embraces a medically related practice model will help us to meet the challenge of maintaining educationally related occupational therapy in the public school setting per IDEA and the Standards of Practice for Occupational Therapy (AOTA, 1994) by three separate reviewers.

### Results

Respondents reported little concern regarding billing of Medicaid for occupational therapy services in the schools (see Table 2). The majority did bill Medicaid for services and reported that this did not affect which students received services. Most continued to provide services that had been regularly provided before implementing Medicaid billing. Seventy-nine reported that billing Medicaid affected documentation; 29 agreed that administrative problems with billing Medicaid hampered services; and 15 reported that occupational therapy assistants have been affected by this billing.

Written comments explaining responses yielded a different picture. Respondents’ comments were categorized into the following eight areas of concern:

1. Paperwork and billing requirements for reimbursement take away from time previously spent in direct care and in collaboration with students, parents, and teachers.
2. Smaller school districts cannot afford to participate in such billing because of increased administrative costs and record keeping.
3. Medicaid funds may become “tapped out” and unavailable once a student reaches adulthood.
4. There are potential ethical issues in billing Medicaid such that some practitioners have thought of resigning.
5. Medicaid supervision regulations for occupational therapy assistants may be different from those of state and professional license boards and, thereby, cause legal and ethical problems. Occupational therapists were being asked to sign off for unsupervised occupational therapy assistants.
6. Children who receive educationally related services may be denied services if they lose their Medicaid benefits. Medicaid enrollment status may encourage or discourage identification and placement.

### Table 1

<table>
<thead>
<tr>
<th>Medically Related</th>
<th>Educationally Related</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assumes an underlying cause with diagnosis based on symptomatology.</td>
<td>Assumes no underlying cause. Focus in on what behavior or functional need is to be accomplished.</td>
</tr>
<tr>
<td>Evaluation to reveal underlying problems.</td>
<td>Evaluation to determine what functional problem needs resolution (i.e., targeted behavioral outcome).</td>
</tr>
<tr>
<td>Dysfunction is within the student.</td>
<td>Dysfunction is a mismatch between student’s abilities and what is being demanded or asked.</td>
</tr>
<tr>
<td>Intervention focuses on “curing” the cause and tends to be long term because underlying causes are often never able to be fully cured.</td>
<td>Interventions focus on function and are more short term.</td>
</tr>
<tr>
<td>Treatment is usually one to one and occurs in a setting outside of the classroom.</td>
<td>Treatment is group oriented and can be in classroom or other school settings.</td>
</tr>
<tr>
<td>Provider uses medical terms that are not generally understood by parents and teachers.</td>
<td>Provider uses everyday language that is understood by parents and teachers.</td>
</tr>
</tbody>
</table>

7. Special education service providers are forced to follow a medical model approach to school-based practice to ensure that services are reimbursed.

8. Billing agencies are editing occupational therapy documentation records to meet Medicaid reimbursement requirements.

Discussion

Respondents’ concerns reveal potential ethical dilemmas for school-based occupational therapy practitioners posed by the Medicaid billing structure (see Table 4). Principle 1 of the Code of Ethics relates to beneficence, or the “obligation to help others further their important and legitimate interests” (Beauchamp & Childress, 1989). Respondents wondered whether a reimbursement system that pays for medically necessary services will benefit only children who are eligible for Medicaid and thus compromise the quality of educationally related services.

Principle 3 pertains to the professional duty to attain and maintain competence, to use appropriate procedures, and to ensure that services provided are commensurate with qualifications and experience. Within a system that encourages the use of medically related contract services, respondents were concerned that therapy expectations might shift away from educationally relevant services to the more limited medically necessary services. They were con-
certained that this system will encourage the inappropriate use of occupational therapy assistants as direct service providers without the supervision by occupational therapists, which is mandated by our practice standards.

**Principle 4** places responsibilities on therapists to, among other things, abide by all local, state, and federal laws; the *Standards of Practice* (AOTA, 1998); and institutional rules. Respondents commented that the Medicaid billing structure might contribute to “double dipping”—the payment of services already paid for by other sources—which violates the therapist’s obligation to abide by the law. Although this principle does not deal expressly with distributive justice, such as balancing the needs of one person against the needs of the community, respondents were concerned that this system could unfairly divert funds away from needy populations other than special education students and deplete the total allowed monies for Medicaid per individual, resulting in “using up” lifetime benefits.

**Principle 5** dictates that occupational therapists provide truthful and accurate information about their services. Respondents expressed concern that providing Medicaid services without some consensus or understanding among school therapists and administrators about the differences between medical versus educational occupational therapy services could create an ethical dilemma for the provider. Many respondents were confused about the difference between medical versus educational occupational therapy services and wondered whether the blending of educationally based and medically based services might result in misrepresentation of services or lack of accountability to families.

**Principle 6** pertains to treating colleagues and other professionals fairly and truthfully. Several respondents believed that providing Medicaid services in the school setting contradicted the therapist’s legal mandate regarding educationally relevant services. They wondered whether these two types of services should be segregated by billing mechanisms. They expressed concern that meeting the school’s needs for Medicaid-reimbursable service was at the expense of the student’s need for educational services to benefit from special education.

The resolution of these potential ethical dilemmas has relevance to schools, the children and families whom ther-
apists serve, and the occupational therapy profession. Currently, thousands of students in special education receive services from at least 7,183 occupational therapists and occupational therapy assistants (U.S. Department of Education, 1998). Implementation of billing Medicaid for school-based occupational therapy services has led to related ethical issues such as those addressing parental consent, student privacy, the legality of billing Medicaid for educational services, institutions where schools aggressively push medically necessary services, and the possible harm done to children who do not receive occupational therapy because they do not qualify for Medicaid.

Many of these concerns are similar to those reported by Ahearn (1993) in a larger scale study of Medicaid billing in the public school setting. Ahearn reported the following concerns: (a) conflicting interpretations about what constitutes a Medicaid-reimbursable service, (b) school difficulty in hiring qualified personnel who meet Medicaid regulations for provider prerequisites, (c) potential school difficulty in planning and managing services to ensure non-publication of services (need for intraagency collaboration), changes in family income that may result in inconsistency in eligibility for Medicaid benefits, and (d) substantial loss of education dollars to support a rapidly growing Medicaid budget. The fact that two studies yielded similar concerns warrants serious consideration.

Limitations
The current study was based on a convenience sample. The findings are not based on calculation of statistical probabilities but identify issues for continued research. The number of written responses by participants for questions 2 through 9 (see Table 2) do not align with only those who responded yes because many who answered no responded anyway, and some who answered yes provided no explanation.

Conclusion
The effects of billing Medicaid for occupational therapy services in the schools warrant further study. This is especially true because reauthorization of IDEA requires that Medicaid be billed for occupational therapy services provided in the school setting. Because this billing structure may put school-based therapists in the position of violating principles of the Occupational Therapy Code of Ethics, we recommend that practitioners be well versed with the code as well as with the billing mechanism in the settings where they work. ▲

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