How High Do We Jump? The Effect of Reimbursement on Occupational Therapy

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This paper explores the extent to which third-party reimbursement dictates occupational therapy practice. A literature review was used to examine the history and meaning of reimbursement in regard to occupational therapy. It was found that the profession has altered its definition, practice, management, ethics, and professional response as a result of changes in reimbursement. Reimbursement policies reflect societal influences and are shaping occupational therapy in several ways. Control has shifted to third-party payers, allowing them to define occupational therapy; use of the medical model is being rewarded by reimbursement; the language used to discuss the profession has changed to accommodate the insurance and other industries; and values that dominate society are being reinforced. Conflict between the values of society and the values of the occupational therapy profession is a source of struggle for many clinicians. If the causes of the reimbursement-imposed constraints on practice are understood, occupational therapists will be free to be proactive in issues of health care policy.

History of Occupational Therapy in Relation to Reimbursement

"Historically, the reimbursement method for occupational therapy has driven its delivery system" (Foto, 1988a, p. 564). The history of occupational therapy reimbursement may be divided into three eras of change: the institution of modern health insurance, beginning in the 1920s and ending in the 1950s; and the control of costs that has begun in the current era of prospective payment (Baum, 1985).

The occupational therapy profession was born out of the Moral Treatment movement in the second half of the 19th century. Moral Treatment signified a change from custodial care of mentally ill people to care based on the "law of love" (Bockoven, 1971, p. 223). Adolph Meyer, whose work preceded the profession, linked occupational therapy to Moral Treatment by describing diseases as problems of adaptation, appropriate use of time as the remedy for habit deterioration, and occupational therapy as the means of teaching the structuring of time (Meyer, 1922/1977). In fact, the first definition of the profession, written in 1918, was "a means of instruction and employment in productive occupation" (Hopkins & Smith, 1978, p. 10). Meyer's philosophy of occupation in mental health strongly influenced the philosophy and history of occupational therapy as a whole (Hopkins & Smith, 1978).

In the decades following the Civil War, although occupational therapy was still in its infancy, the philosophy of Moral Treatment, as used in mental health, was already declining. This decline was largely due to a shift in popu-
lar thought from a moral-emotional model to a technological-pathological approach in which the scientific method was embraced (Bockoven, 1971). This happened in spite of the established efficacy of Moral Treatment (Bockoven, 1971; Peloquin, 1989). Mental health also shifted to an organic, pathology-based frame of reference in the early 1900s (Bockoven, 1971).

The shift in popular philosophy affected not only mental health practice but the entire medical community (Bockoven, 1971). The Flexner Report, published in 1906 (see Feldstein, 1987), marked a change in the philosophy underlying medical treatment. Generated by the American Medical Association in an effort to upgrade the quality of medical schools (Feldstein, 1987), the Flexner Report emphasized a unifactorial, biomedical, scientific model of disease. As a result of the report, medicine shifted to more scientific, laboratory-based concepts (Waitzkin, 1978).

During the formative years of the profession, occupational therapy persisted in its view that adaptation to and engagement in the environment were strong components of health, in spite of differing popular philosophy (Bockoven, 1971). However, the financial constraints of the depression years precipitated a significant turning point in the profession's development. In the middle of the 1930s, the American Occupational Therapy Association (AOTA) asked the American Medical Association to establish standards for training institutions and take over accreditation of occupational therapy schools. It was this decisive step that formally placed occupational therapy in the position of a medical ancillary (Rerek, 1971). This action, although it achieved its purpose of survival, limited nonmedical practice opportunities for the future in that occupational therapy was now tied to the health care industry by educational standards and financial concerns. Thus, the profession's struggle between its roots in Moral Treatment and the medical model/scientific method began.

From the 1940s to the 1960s, occupational therapy was involved in the rehabilitation movement, which began with the return of World War II disabled veterans. New antibiotic medications and advanced methods in surgery helped injured soldiers survive their wounds, and rehabilitation helped them to be independent with the resulting disabilities. Rehabilitation was also economically advantageous. During this time, association with the rehabilitation movement (and possibly with the medical community) made occupational therapists "uncomfortable with their simple operating principle that it was good for disabled people to keep active" (Mosey, 1971, p. 235). New treatment methods (e.g., orthotics, vocational evaluation, neuromuscular facilitation), borrowed from other professions, were added to the occupational therapists' repertoire at a pace so rapid that it was impossible to assimilate these changes into the profession's theoretical base (Mosey, 1971).

The rehabilitation movement was accompanied by changes in payment for health care services. Before this, health insurance had been based in local, private systems. Increases in the cost of medical care exceeded the limitations of this system. National health insurance was debated, but instead payment for health care was installed as an employee benefit controlled by private industry. The American Medical Association successfully campaigned against national health insurance, in conjunction with organized labor, which wanted to retain health insurance as a bargaining tool (Somers & Somers, 1961). The medical profession fought national health care coverage because it viewed "involvement of the federal government as a fatal intrusion in the hallowed doctor-patient relationship and believed that it would lead to the increasing bureaucratization of medicine" (Luft, 1978, p. 3). By the middle of the 1960s, physicians no longer had enough political power to stop government-supported health insurance (Luft, 1978), in part due to the increased political power of consumer groups (Freidson, 1975). With more support for government involvement in health care, Medicare and Medicaid were born in 1966. With their advent, the established traditions of payment and organization in health care were permanently altered (Freidson, 1975).

Few changes in the provision of services were anticipated with the start of Medicare. Diasio (1971) recognized that Medicare and Medicaid would allow the development of occupational therapy in community health care for the elderly and the poor. Reilly (1966) feared that an increased use of paramedical staff, including therapists, would cause funds for their wages to be spread thin, causing salary stagnation and the dreaded threat of symbiosis with physical therapy. As occupational therapists clarified their role, however, and as the use of more paramedical staff (therapists included) resulted in a shortage of therapists, Reilly's fears did not come true (Baum, 1985).

From the 1960s to the early 1980s, occupational therapy continued to enjoy a political climate favorable to health care, and its services grew (Davy, 1984a). However, costs began to escalate as health care facilities took advantage of available capital. Consequently, Congress set limits on Medicare reimbursement as part of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97–248). In the following year the Social Security Amendments of 1983 (Public Law 98–21) were enacted, which set the stage for the phasing in of prospective payment and diagnosis-related group (DRG) forms of reimbursement (Russell, 1989).

With the cost constraints of the late 1970s and 1980s and the inception of prospective payments, occupational therapists found that accurate documentation was crucial to reimbursement (AOTA, 1989). In addition, demand for inpatient occupational therapy services decreased, and demand for outpatient services increased (Foto, 1988a).
Shorter hospital stays have resulted in higher volumes of patients for occupational therapy services; further, the new payment system encourages provision of "the fewest number of services possible" (Baum, 1985, p. 779) to meet goals. All of this has led to concerns over how to maintain service quality (Baum, 1985). For example, occupational therapists have found that their poorer clients receive limited support from government programs for therapy services. Thus, clinicians must struggle to provide helpful services during limited contact with these patients (Foto, 1988a).

In 1986, Congress passed the Occupational Therapy Medicare Amendments (Section 9337 of Public Law 99-509) in response to the need for more community-based treatment. These amendments extended full coverage to occupational therapy services under Medicare Part B. Payment was authorized for patients in skilled nursing facilities, rehabilitation agencies, home health care, and private practice (AOTA, 1989). Medicare Part B coverage has provided financial support for the expansion of private practice and contractual occupational therapy services in the past few years.

**The Effect of Changes in Reimbursement on the Profession**

The current environment of cost containment leaves occupational therapists "caught between the pressures of patients' demands for quality care and the drive to contain costs," which "creates professional and emotional conflict" (Foto, 1988a, p. 564). The effect of reimbursement on the definition of occupational therapy and on practice, management, professional ethics, and the profession's response will be discussed in the following paragraphs.

**The Definition of Occupational Therapy**

The definition of occupational therapy has been shaped by changing reimbursement patterns. In a special issue of the *American Journal of Occupational Therapy* (Davy, 1984c), detailed articles supplied information on coverage available for various practice areas of occupational therapy. This implied that what occupational therapists can do, and therefore what they are, is defined at least in part by what is reimbursed. In addition, what is not covered is outlined so that therapists do not perform non-covered services, or at least do not define what they do in a noncovered manner. In the same issue, Davy (1984b) described the great lengths to which the profession has gone to get itself defined by insurance companies in order to ensure coverage.

Further substantiation of this point is found in *Medicare Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual* (Department of Health and Human Services, 1989). Section 503 of this document, entitled "Guidelines for Submitting Claims for Outpatient Occupational Therapy Services," defines the services that are covered under Medicare Part B. One important feature of this document is its definition of what is not occupational therapy: If it is not in the guidelines, it is not paid for. Therefore, clinicians cannot perform or document services that are not in the guidelines if they wish to obtain reimbursement under Medicare Part B. Because this document is becoming a standard used by most insurance companies, its significance in defining occupational therapy is substantial. Fortunately for the profession, occupational therapists assisted in its development at the government's request (AOTA, 1989).

**Practice**

Because the descriptions of the coverage available in various practice areas are used by occupational therapists in documenting their services, occupational therapists must now treat within the boundaries of these descriptions. Clinicians may therefore find themselves changing or limiting their modes of treatment to comply with reimbursement restrictions. For example, the occupational therapy guidelines for Medicare Part B specifically state that daily feeding programs are not considered skilled occupational therapy once the adapted procedures have been implemented (AOTA, 1989). Therefore, an occupational therapist may design a feeding program for a patient in a skilled nursing facility with Medicare Part B coverage but may have limited financial support for continued intervention. Patients with Medicare coverage are not the only ones affected. Outpatient care is another clinical area in which limitations in various forms of reimbursement dictate occupational therapy service provision: "Many times, because of a patient's lack of health insurance, we must turn even the most appropriate treatment candidates away from our [outpatient] departments" (Burke & Cassidy, 1991, p. 174). Not only the frequency but also the nature of treatment has changed. Clinicians are now asked to provide diagnosis-based treatment protocols that will guarantee coverage for services. These protocols may or may not fit in with individual patient needs (Burke & Cassidy, 1991).

At a deeper and more disturbing level, changing reimbursement patterns have caused shifts in the definition of occupational therapy that have led, in turn, to changes in professional roles (e.g., occupational therapists' role with the chronically ill). Reilly (1971) explained the disparity that led to this change:

> There is an enormous obstruction outside the control of the profession that seriously impairs the delivery of service. It is the absence of economic support to chronic medicine. The commitment and hence the capitalization in medicine is directed toward the reduction and prevention of pathology and the treatment of acute phases of illness. Occupational therapy makes its investments in the health residual which follows pathology and hence...
Indeed, program design and treatment of acute phases of chronic illness are currently among the few occupational therapy services for persons with chronic illness that are supported by Medicare (AOTA, 1989).

New directions in reimbursement provide the capital for the development of new and existing clinical areas. Foto (1988a) gave examples of occupational therapy’s ability to provide what insurance companies now want (e.g., wellness programs, reduced hospital stays, treatment at a lower level of care [therapist rather than physician] where appropriate, the return of patients to the highest possible functional level). She wrote, “Since occupational therapists offer these services, we should be in demand. But we must educate the industry . . .” (Foto, 1988a, p. 564). Her statements suggest that shifts in reimbursement will shape occupational therapy by the profession’s need or desire to be where the reimbursement is. For example, records of facilities developed recently indicate that they include skilled nursing homes, outpatient services, and home health care (Russell, 1989). Could it be that, with the 1986 change in Medicare Part B reimbursement, these areas are once again profitable for occupational therapy? One could argue that the recent surge in the number of contracting agencies providing therapies for these clinical areas is another direct result of improved reimbursement. The type and quality of therapy services also appears to have changed with this resurgence: Agencies are reimbursed on a treatment unit basis, so therapists must account for their time by units of productivity. This means that little time is left to develop programs for services to chronically ill people or non-reimbursable nursing home residents.

The current climate of cost containment may have an effect on available treatment technology. This trend is hard to predict due to the varied nature of regulation and the effects of national values and lobbying groups on federal legislation. Aaron and Schwartz (1984) speculated that in the case of high-technology equipment, “the demand will be fully met in some cases; in others, constraints on expenditures will reduce either quality or quantity” (p. 115). What will this mean for occupational therapy? It may mean that patients will have to be prioritized for available equipment and that treatments that rely on high-technology equipment will go up in cost because of lower supply and higher demand. This could lead to greater access to technology for those who can pay and less access for the poor.

Management

Changes in reimbursement have also meant changes in management style for occupational therapy departments. Productivity and efficiency are becoming high-priority goals, because departments must handle more patients with fewer staff. Changes to increase productivity may include attempting to meet treatment goals in fewer treatment sessions; performing evaluations and treatments that focus on decreasing lengths of stay by addressing primarily the problems that are keeping patients in hospitals, and use of occupational therapy assistants, aides, volunteers, and part-time staff to meet treatment goals at the lowest cost possible. An emphasis on efficiency could require computer documentation for faster charting and evening and weekend treatment to speed recovery (Scott, 1984). Such programs for increased productivity need to be studied to determine their efficacy and to determine whether they allow patients sufficient time for the rest needed to recover.

In addition to changes in program design, productivity concerns cause managers to justify staff positions based on reimbursement data. Foto (1988b) suggested the use of the Medicare cost report to justify hiring more staff. This report covers not the number of treatments given, but the number of treatments reimbursed. Foto’s suggestion highlights the fiscal constraints under which managers are operating and the extent to which reimbursement issues are linked to clinical issues.

Ethics

Reimbursement constraints can influence changes in professional ethics. The Occupational Therapy Code of Ethics, Principle 1, Item H, states: “The individual shall establish fees, based on cost analysis, that are commensurate with services rendered” (AOTA, 1988, p. 795). In light of cost constraints and the need to justify staff, there is a risk that this principle may be interpreted loosely, resulting in ethical abuses. Possible abuses include overbilling for services (e.g., rounding up times), providing services that are not necessary for functional goals, overpricing of services, overworking employees to maintain revenues, and focusing efforts on those programs that bring in revenue but are not clinically effective (Mullins, 1989).

Reimbursement concerns raise new ethical questions: Is it ethical to make changes in the provision of services based on the patient’s method of payment, or on the basis of reimbursability rather than diagnosis? Discrimination in providing health services may work both ways: The nonreimbursable patient may receive subminimal care, which compromises quality, and the patient with ample reimbursement may be treated beyond the limit of goals for cost containment. The free market medical system provides few checks and balances:

The market is the provider’s best friend. It gives providers license to supply inaccurate information, to limit service only to those patients with an ability to pay, to charge whatever they wish, and to reduce quality of care to achieve greater profitability. (Sloan, Blumstein, & Perrin, 1988, p. 237)
The Profession's Response

The responses of occupational therapy as a profession to changes in reimbursement fall into three categories: regulation, public relations, and political action. Although the justification for regulation (licensure) of health care professionals has been consumer protection (Sloan et al., 1988), an equally important consequence for occupational therapy is improved reimbursement (see Moyers, 1988). Licensure of occupational therapists exists in 46 states (Jaervnick, 1991).

Increased dialogue and public relations efforts with third-party payers will distribute control of the health care industry more equally between providers and payers (Hertenstein, 1989). Occupational therapists who enter into dialogue with insurance companies must be prepared to address the insurance industry's needs (Foto, 1988a) and use the industry's language of functional independence and patient dignity to discuss occupational therapy services (Foto, 1988b). By addressing insurance industry concerns, occupational therapists may find it necessary to compromise on clinical issues. Other responses to reimbursement concerns include mobilizing to accommodate managed care, breaking through coverage barriers of health maintenance organizations (Foto, 1988b), and recruiting new occupational therapists so that services will continue to be available at a lower cost level (Baum, 1985).

Political action within the profession consists of lobbying for a better understanding of occupational therapy issues among legislators (Baum, 1985; Foto, 1988b). Being politically active is crucial to taking a proactive stance in managing change in health care (Foto, 1988b).

Discussion

Occupational therapy does not exist in a vacuum; societal influences are a dominant factor in precipitating change. Neither research nor pure theory appears to have the impact on occupational therapy practice that society does. The societal influence of reimbursement for health care has substantially affected occupational therapy in definition, practice, management, ethics, and the profession's response. Reimbursement has altered occupational therapy by at least four means: control, understanding (e.g., of disease), language, and values.

Control

It is a Marxist premise that increased concentration of capital in the hands of the few leaves others unempowered (Waitzkin, 1978). With capital for health care centralized in insurance companies and government programs, it is to be expected that these third-party payers exert great control over the health care system. Control in occupational therapy has been altered by placing the definition of the profession, in part, in the hands of those who hold the capital. In other words, occupational therapy is being controlled to some extent by payers who participate in defining it. Examples, mentioned earlier, include the proliferation or demise of specialty areas according to reimbursability (as with the increase in hand therapy and work hardening and the decrease in inpatient care and contact with pediatric clients); changes in service provision according to coverage (e.g., limited provision of services to patients with limited reimbursement); and the need to justify the number of staff members in occupational therapy departments by the number of treatments reimbursed.

Understanding

Virchow, who studied social epidemiology and social medicine, focused on two major themes regarding the understanding of disease. He believed that the origin of disease is multifactorial (not just physical) and that successful improvements in health care must be the result of concurrent improvements in economic, political, and social reforms (as cited by Waitzkin, 1978). One can extrapolate from Virchow that it is necessary to maintain a consistent understanding of the whole health care system, the ways it seeks to remediate disease, and the economic and political changes that affect the system.

Shifts in popular ideology have caused occupational therapy to change its understanding of itself. For example, the modern urgency for research attempts to establish occupational therapy within the biomedical/scientific model, indicating how far occupational therapy understanding has shifted from its connection to Moral Treatment philosophy. Research, therefore, becomes not just a measure of efficacy, but a method to justify occupational therapy according to the dominant model in health care practice. Because reimbursement rewards the unifactorial medical model, it becomes difficult to survive economically while clinging to a philosophy based on multifactorial causes of disease. Compromise—by assimilating aspects of the medical model—allows for survival, but limits options for social effectiveness.

Language

Sapir and Whorf (Sapir, 1929) developed a hypothesis of linguistic relativity that held that the way things are talked about affects understanding of them. When this hypothesis is applied to occupational therapy, the way the profession is discussed changes how it is perceived. Subtle changes in occupational therapy philosophy have occurred simply through changes in the language with which thoughts are framed. By using the language of insurance companies (e.g., skilled occupational therapy) in documentation and definition, occupational ther-
apy shifts into new clinical dimensions (e.g., use of objective tests and measurements) and discards old practices (e.g., use of activity for its intrinsic qualities). Framing occupational therapy in the appropriate language makes it acceptable and reimbursable to third-party payers. Language has affected management in particular; the words cost containment, productivity, and efficacy now occupy and shape the department manager’s thoughts (Gray, 1983; Mullins, 1989).

Values
In our society, individualism and private enterprise are valued. With cost containment, the prevailing values in health care become clearer: Technology and the scientific method are valued more than the holistic use of a variety of treatment methods; the young and productive are valued more than the old and frail; and acute treatment is valued more than chronic care (Waitzkin, 1987). Reimbursement within a system that embraces these values shapes the practice of occupational therapy. What our profession valued at its inception contrasts with the values of the current health care system; the tension between societal values and the values of the profession continues to be a source of conflict for many clinicians.

Implications
How high do we jump? Should reimbursement dictate clinical practice? No one sector of society should control the health care field or any aspect of it. Accountability is a necessary part of participation in health care to ensure a broader distribution of power so that all interested parties may be assured of representation. The fact remains, however, that third-party payers have exerted substantial control over the profession, with an unclear understanding of how occupational therapy has influenced trends in reimbursement. It is also unclear how much say patients have in occupational therapy practice.

Occupational therapists occasionally need to step outside of the health care arena and view the interplay between the various sources of control in health care, so that reasons for actions and reactions will become clearer. For example, when clinicians understand the financial pressures that their health care institutions face, it is easier to view frustrations with service provision to individual patients as symptoms of a larger problem. It is also imperative to view the profession from the point of view of the other players—the patient, the insurance carrier, and other disciplines—so that cooperation and dialogue are welcomed when occupational therapy’s role in the health care system is negotiated.

Occupational therapists also need to understand who they are as occupational therapists. Proactive, systematic vocational planning is then possible (Howard, 1990). Vocational planning includes defining ethical practice, framing the definition in language that is not easily bent, and lobbying for it through public relations activities and political action. It also includes examining the conflicting goals of quality service and cost containment and setting guidelines by which to practice within the boundaries of both.

The occupational therapist may use other means to maintain a fair distribution of power. Baum (1985) recommended looking to payment sources other than third-party payment to free occupational therapists to be self-directive. She mentioned workers’ compensation, liability insurance, corporate funds, public health funds, and Social Security as a few examples. Another option is to practice in nontraditional (i.e., nonmedical) settings that allow greater impact on patient populations without reimbursement constraints. Occupational therapists working as employee health directors in industry are an example of nontraditional practitioners with an impact on prevention. A third means of vocational planning is volunteerism. If higher salaries and staff shortages are contributing to escalating costs and limited access for poor and rural patients, then volunteering is one option. Although most occupational therapists do not have the opportunity for full-time volunteer work, some are able to donate an hour a week to a free clinic. Others are able to offer a week or two a year of consultation services to programs for needy people. Still others participate in local and national advocacy groups for persons with disabilities.

We as occupational therapists must be aware that social factors influence the direction of the profession. Reimbursement issues not only frustrate clinical practice but participate in shaping occupational therapy. We must be aware of the causes of constraints on practice in order to be proactive in issues of health care policy.

References


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