Status Report on Reimbursement for Occupational Therapy Services

Jane D. Davy

Current Environment
A recurrent headline in newspapers, magazines, and journals is the rising cost of health care in this country. This is not a new problem. From the time health insurance first became available in the 1930s, to the enactment of the Medicare law in 1965, until today, health care costs have risen steadily. The cost of the Medicare program has been repeatedly underestimated by Congress. The advancements in medicine and new technologies have produced new solutions to problems and a longer life span for Americans. At the same time, the elderly population has increased, and decisions about whether insurance should pay for new technologies and heart, kidney, and lung transplants have created new problems for America's struggling health care reimbursement system.

Although the costs associated with health care have been high for many years, this problem was not viewed as critical by government, business, or consumers until the 1980s. Seventy-five percent of Americans surveyed in a 1983 study reviewed the U.S. health care system as in need of major changes (1). This view was shared by major employers, insurance executives, unions, and a majority of hospital administrators. Members of the medical profession, however, believe that the health care system works pretty well with only minor changes necessary.

The major problems identified through the survey were the cost of hospitalization, the lack of competitive pricing by providers, and the lack of incentives for patients and providers to cut costs. Some of the solutions most acceptable to those surveyed to alter the health care system include alternatives to the use of hospitals, increased cost sharing with the consumer, increased deductibles, insurance rate incentives for preventive care, prepaid plans, and preferred provider plans. Because the problems related to paying for health care have been viewed as critical, many changes in the system have already been made by business, hospitals, physicians, and individuals.

In 1983, Congress initiated the first major change in the Medicare program since its inception in 1965 by enacting the hospital prospective payment system. In addition to changing the manner in which hospitals are now paid, Congress is also studying long-term care, including psychiatric and rehabilitative care, for methods to alter the payment system from cost-based retrospective to prospective payment. Because in the future the system will probably not be confined just to hospitals or Medicare, it is important that all occupational therapy personnel become familiar with the new Medicare prospective payment system described in this issue of AJOT.

Private businesses typically offer excellent health care insurance to their employees, and the rising cost of premiums has led industry to make some significant changes. For example, the Borden Company increased their plan's deductible from $100 to $150, and dental benefits were increased. At the same time, the company instituted an employee health education program to explain the changes and provide information on preventive health. In 1982, employees were asked to pay part of the cost of the first days of hospitalization. Although additional cost sharing was phased in later, benefits such as long-term disability were added.

Another company, DuPont of Delaware, changed its health care plan to require more cost sharing up front but, in return, provided catastrophic protection. Other organizations have encouraged employees to join health maintenance organizations (HMOs) or preferred provider organizations (PPOs) (2). (Both HMOs and PPOs are discussed in this issue.)

Although there were only 107 PPOs identified (3) as of fall 1983, this alternative health care delivery system is rapidly growing and expanding.
Ron Wyden (D-Oregon) introduced a bill in Congress that he believes will encourage the expansion of PPOs. Few nonphysician providers have been incorporated into PPOs; therefore, occupational therapy personnel need to introduce their services and try to be incorporated into the PPO structure. No AOTA action or state law is going to mandate certain occupational therapists as preferred providers in a local PPO. As in business, if you want an interest in its development, you have to know the players, and get in on the ground floor. Preferred provider organizations provide a new reimbursement source for therapists who take the initiative. During recent years, consumers have become more aware of their health care coverage and the problems related to the system. The national survey (1) indicated that a majority of the American public is concerned about problems related to health care coverage and services. A consumer group called People's Medical Society in Pennsylvania began evaluating hospitals in December 1983 through surveys of physicians, nurses, and consumers. The group plans to evaluate nursing homes and physicians also. Although surveys are subjective, the group plans to collect information on hospitals, including nosocomial infection rates, the number of malpractice suits filed against staff physicians, cesarean section rates, mortality rates, and length of stay for different diagnoses (4). If the growth in membership of the People's Medical Society is an indicator (1,000 new members per week), consumers certainly want this type of information (4).

Reimbursement for Occupational Therapy

Amidst this climate of cost containment, occupational therapy personnel are struggling with a reimbursement system that does not consistently reimburse certain occupational therapy services, especially outpatient services. During the past few years, coverage for occupational therapy in home health has expanded under Medicare, Blue Cross/Blue Shield, and in many commercial insurance plans. Hospice care coverage, including occupational therapy, has also expanded. Many insurance companies have expanded their home benefit because it has been shown to reduce inpatient days. Maryland Blue Cross/Blue Shield reported an average 8.9 days of hospital inpatient care saved for each of the 1,445 patients placed on the home care program in 1982 (5).

Bills to amend the Medicare law have been introduced in Congress by Representative Lindy Boggs (D-Louisiana) and Senator Spark Matsunaga (D-Hawaii). These bills would allow expanded outpatient coverage of occupational therapy services under Medicare and would provide reimbursement under Part B Medicare in skilled nursing facilities. Although Congress is concerned with expanding Medicare benefits, AOTA maintains that cost savings will accrue to offset the cost of the bill. Often, especially during an election year, Congress will seek new Medicare benefits that have any hope of saving money in other aspects of the program. The Boggs/Matsunaga bills contain these kinds of benefits.

Many local and state occupational therapy groups are approaching Blue Cross/Blue Shield and commercial insurance companies to request coverage of outpatient occupational therapy, and they encounter stiff opposition. Insurance companies are hesitant to offer any new benefit that might increase the premium. Since no one has ever determined the cost of an outpatient occupational therapy benefit, countering the insurance companies' concern is difficult, especially because there is little data relating cost savings to the receipt of occupational therapy services. Insurance companies have not undertaken such cost analyses for a number of reasons. To begin with, there has been no evident consumer or employer outcry to add outpatient occupational therapy benefits to policies, which would provide an incentive to attempt a cost estimate.

Second, insurance companies with policies covering outpatient occupational therapy do not collect data on the number of treatments given or on the charges for occupational therapy. Outstanding departments may not specifically bill for occupational therapy, and insurance companies usually code certain charges from a number of different providers together. Consequently, costs under a given category represent more than occupational therapy. Although universal coding systems are used to code professional services such as the widely used Physician's Current Procedural Terminology (CPT) (6), both physicians and nonphysician providers may use the same codes to describe their services. Thus, the amount for a certain type of service, such as an "evaluation," is determined, but not the cost according to provider.
Finally, although some well-informed employers would like to include occupational therapy in their health benefit plans, it is simply something they can't afford to add when consumers are demanding such things as paid physician office visits and dental benefits. Likewise, while many insurance companies are aware of the benefits of occupational therapy, they believe it is a benefit that is "nice to have," but is not essential to a plan where the premium cost is a major issue.

These factors have helped create a climate where increased reimbursement is difficult to achieve. One positive factor is that insurance companies and the Congress are seeking methods to reduce hospitalization, the most expensive aspect of health care. Insurers also are looking more favorably on rehabilitation. Equitable Life Assurance Society recently made a rehabilitation benefit available to purchasers as part of its major medical plans. Blue Cross/Blue Shield reported that insurance coverage for treatment of alcohol and drug abuse will be more widely available as a result of a three-year demonstration project. Company officials believe this benefit can be marketed successfully to employers because of its potential for saving money through decreased absenteeism, late arrivals, and industrial accidents. This particular benefit has shifted from traditional inpatient hospital alcohol and drug abuse treatment to an emphasis on outpatient care in both community residential programs and free-standing clinics.

These changes represent modified thinking within an insurance industry that for so long emphasized inpatient care through the benefit structure. Although insurance companies are fearful of expanding benefits without increasing premiums, some are now oriented toward paying for nonphysician services provided in nontraditional settings. In addition, industry is expanding health benefits through the development of wellness programs administered on the job. In many ways, health care is leaving the health care facility and coming directly to industry and the community. This is an opportunity for occupational therapy, but it requires individual action at the local level.

**AOTA's Position**

Considering the cost-cutting attitude of the Congress and insurance companies, the need for nationwide efficacy data and cost effectiveness information about occupational therapy has become critical. Therefore, AOTA has launched an effort to obtain and disseminate such data. In November 1982, AOTA began the Efficacy Data Project. Project staff began collecting research findings on the efficacy and cost effectiveness of occupational therapy and synthesized the information needed is not available in a single study, four approaches have been designed to measure the impact of occupational therapy services on hospital length of stay and patient outcomes.

The first approach is a literature search. This is a critical review of all the literature dealing with the impact of occupational therapy on length of stay, functional outcomes, intensity of nursing services, and discharge disposition. An analysis of current statistics will provide a summary of available data. This is an essential part of any major research effort.

The second project involves a survey of existing data bases, such as those compiled by the American Hospital Association. This project will determine whether information is available on length of stay in relationship to the provision of occupational therapy services and other more detailed information, if available.

The third project, and the most expansive, involves collecting new data on approximately 500 patients in about 50 hospitals across the country. This project will possibly use regional research and quality assurance consultants as field liaisons and necessitates the involvement of members as well. The main thrust of this study, as initially perceived, is to compare length of stay for patients receiving occupational therapy with matched patients who do not receive occupational therapy.

The final project is an opinion survey. A postcard questionnaire will be sent to about 8,000 hospital administrators and physicians selected as most likely to have knowledge of occupational therapy. Again, the questions will focus on cost effectiveness of oc-
Occupational therapy services considering length of stay and patient outcome status. These four projects represent the most significant step AOTA has taken to accumulate data to increase reimbursement for occupational therapy.

What Can Members Do?
State and district occupational therapy associations and individual members can play a significant role in maintaining and increasing occupational therapy reimbursement. Individual therapists can urge their Congressional representatives to work for approval of the occupational therapy Medicare bills introduced by Representative Boggs and Senator Matsunaga. For those occupational therapists working in private practice and nursing homes, these bills should be a high priority.

Occupational therapists can also work with their state associations to monitor Medicaid funding for occupational therapy. Medicaid plans are subject to amendment each year, and in states with financial difficulties, occupational therapy and other rehabilitative services may be deleted as covered services to save money. Occupational therapy is one of the many optional services under Medicaid that a state may choose to provide. In states where occupational therapy coverage is threatened, state association efforts will need dedicated member support.

In addition to organized member efforts, each therapist should take a careful look at ongoing documentation. Inadequate documentation due to high case loads and nonpatient related responsibilities can often result in reimbursement problems. Medical care, for instance, has precise guidelines that should be followed carefully when documenting occupational therapy services (see Medicare Guidelines in this issue, p. 355). In many cases, documentation may need to be streamlined with forms and checklists in order to increase productivity while still maintaining reimbursement.

Good documentation of occupational therapy services is also important for describing typical services and program protocols. When an insurance company claims reviewer questions a claim, a factsheet describing the general service provided may be sufficient to educate the claims personnel about occupational therapy. This is particularly helpful when occupational therapy is not listed as a specific benefit in the policy, but the types of treatment are within the scope of the plan and can be covered administratively.

Finally, each occupational therapist should examine how they maintain statistics in their own work setting. Are occupational therapy services clearly separated from other rehabilitative services? Is the uniform terminology being used in part or in total for easy data collection? Is it possible in your setting to collect information such as the number of occupational therapy treatments per stroke patient and the amount billed for that service? Do your medical records clearly document initial and discharge status of the patient? Research is only as good as the information available, and without adequate documentation, good data on the efficacy of occupational therapy treatment can never be established.

In addition to demonstrating good skills and establishing a framework for collecting information, many occupational therapists want to learn how to improve the cost effectiveness of the occupational therapy they provide. The regional quality assurance consultants can assist members in this task. They will be teaching seminars on how to conduct quality assurance studies that improve the cost effectiveness of care (8).

Summary
Reimbursement sources for occupational therapy are growing, not diminishing, but the ability to increase reimbursement through these new sources is becoming more difficult. Collecting efficacy data and documenting services provided are important methods for increasing reimbursement. If the quality of occupational therapy services remains high, reimbursement is more likely to follow.

REFERENCES
5. The Blue Cross/Blue Shield Consumer Exchange. Washington, DC: Blue Cross/Blue Shield, December 1983
8. For information regarding upcoming seminars, contact Quality Assurance Division: Rockville MD: AOTA