Health care spending in the United States (U.S.) reached $3 trillion, or $9523 per person, in 2014 (Centers for Medicare & Medicaid Services [CMS], 2015e). This chapter describes various funding sources and provides an overview of the billing and reimbursement process. Also addressed is the necessity of documenting services as skilled occupational therapy in accordance with established legal and ethical standards. It is important to realize this manual contains information based on current practice guidelines and legislation at time of publication. Reimbursement criteria and documentation requirements change as new laws are enacted and health care systems evolve.

Health Care Funding Sources

Individuals can pay providers directly for health care services received but the majority of health care is funded through a wide range of public and private health insurance programs and managed care plans. Local, state, and federal governments combined funded nearly half of total U.S. health care spending in 2014. Federal spending alone increased 11% over the prior year, primarily due to Affordable Care Act (ACA) provisions, such as Medicaid enrollment expansion (CMS, 2015e). As a result, payers have been moving toward reimbursement aligned to outcomes that justify treatment over the fee-for-service model (DeJong, 2016). Various attempts at more cost-effective ways of improving client outcomes and providing value-based care have been implemented, such as quality measures, bundled payments, and episode-based management, influencing how occupational therapy and other health services are managed, delivered, and paid for (DeJong, 2016).

Third-party payers (e.g., insurance companies, managed care plans, governmental programs) vary greatly regarding program eligibility, premiums, out-of-pocket expenses, provider networks, and plan benefits such as types of coverage for prescriptions, mental health services, catastrophic care, rehabilitation services, medical equipment/supplies, etc. Health providers and suppliers (e.g., institutions, agencies, medical equipment vendors, pharmacies, and individuals, such as physicians and therapists in private practice) contract with various third-party payers to be an approved health care provider for patients with that insurance. For reimbursement, these contracted providers agree to accept assignment which are the predetermined amounts the insurer will pay for each covered service or supply if certain criteria are met. This allowable amount is considered payment in full and the provider “may not bill or collect from the patient any amount other than unmet copayments, deductibles, and/or coinsurance” (CMS, 2015d, p. 15). Thus, if a patient receives health services or supplies from a provider that accepts his or her insurance plan, all sides agree to those terms in regard to what is or is not covered as a benefit and the maximum amount the patient and insurer will each have to pay to the provider. The billing and reimbursement process will be explained in more detail a little later in this chapter.