

Client-Centered Advocacy: Every Occupational Therapy Practitioner's Responsibility to Understand Medical Necessity

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MeSH TERMS

- health services needs and demand
- insurance coverage
- occupational therapy
- patient advocacy
- Patient Protection and Affordable Care Act



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Occupational therapy practitioners must advocate for clients in multiple ways. The *Occupational Therapy Practice Framework: Domain and Process* as well as the *Occupational Therapy Code of Ethics* lend support to advocacy. Recognizing one's responsibility to provide advocacy for clients is different from knowing how to provide that advocacy. One aspect of health care affected by the Patient Protection and Affordable Care Act (ACA) is the definition and implementation of *medical necessity*. This article outlines some major concepts around medical necessity, particularly in relation to the passage of the ACA, and outlines guidance on how to advocate effectively to meet both individual and community needs.

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The professional promise of occupational therapy practitioners is to help clients “live life to its fullest” (American Occupational Therapy Association [AOTA], n.d.). AOTA's mission is to advance “the quality, availability, use, and support of occupational therapy through standard-setting, advocacy, education, and research on behalf of its members and the public” (AOTA, 2014a). These statements, along with the advocacy language in the *Occupational Therapy Practice Framework: Domain and Process* (3rd ed.; AOTA, 2014b), recognize that the role of occupational therapy practitioners often expands beyond the pure treatment realm. An occupational therapy practitioner is an educator, a counselor, a motivator, a coordinator of care, a trusted confidant, and an advocate. Working in these different roles, practitioners perceive the overlap between the health and legal fields, from standards of care to practice guidelines to expansions of or limitations on coverage imposed by legislation or payer rules. Through these experiences, occupational therapy practitioners discover that the medical lens is only one lens through which to view a problem. To maximize the legal,

policy, and related lenses, advocacy is a vital skill.

The *Framework* defines *advocacy* as “efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to fully participate in daily life occupations. The outcomes of advocacy and self-advocacy support health, well-being, and occupational participation at the individual or systems level” (AOTA, 2014, p. S30). These aims can be accomplished through direct advocacy efforts or through supporting and training clients in self-advocacy. An effective advocate has knowledge of what services or benefits are available and how they are accessed; an important element of interpreting this knowledge is the ability to understand and define key terms. In health care, the term relevant to almost all resources is *medical necessity*. Occupational therapy practitioners must become experts in interpreting and defining *medical necessity* to be successful in advocacy and training in self-advocacy.

Beneficence, Justice, and Veracity

The *Occupational Therapy Code of Ethics* (AOTA, 2015) requires occupational therapy

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practitioners to become skillful advocates for their clients. Advocacy embodies the principles of beneficence, justice, and veracity. To manifest beneficence, “occupational therapy personnel shall demonstrate a concern for the well-being and safety of the recipients of their services” (AOTA, 2015, p. 2). The *Code of Ethics* (AOTA, 2015) states that “the term *beneficence* connotes acts of mercy, kindness, and charity” (p. 2) and identifies examples of beneficence, including “protecting and defending the rights of others, preventing harm from occurring to others, removing conditions that will cause harm to others, helping persons with disabilities, and rescuing persons in danger” (p. 2).

Generally, an *advocate* is a person “who argues” or pleads “the cause of another person” (*Merriam Webster’s*, 2016). At its core, *advocacy* is demonstrating a concern for a person’s well-being by assisting in the pursuit of that person’s cause. Moreover, when practitioners advocate for their clients, they are often performing activities that are not considered billable services; they are writing letters, attending meetings or hearings, researching laws and regulations, or engaging in phone conferences. The duties of an effective advocate often expand beyond the traditional elements of most health care professionals’ treatment intervention, but these duties may be required to ensure clients’ well-being, safety, and access to necessary care. Advocacy and the ability to interpret and define terms such as *medical necessity* can be necessary elements of the ethical obligation to exhibit beneficence.

Inherent in ethical standards of occupational therapy practice are the concepts of fair public policy and social justice. An article published in *Pitt Law Magazine*, “The New Social Justice,” asserted that “the law is only one lever to wield for social justice” (O’Toole, 2014, p. 12). In the article, University of Pittsburgh Law School Professor David Harris stated that “the legal process should be seen as only one way to bring social justice concerns into . . . the community” (Harris, cited in O’Toole, 2014, p. 12). Advocating for their clients opens the door for occupational therapy practitioners to encourage justice for the public. Practitioners can advocate to legislators for language and regulations that

expand occupational therapy coverage and codify favorable definitions of terms such as *medical necessity*, eliminate service limits, and increase funding for programs that provide services for people with disabilities. They can advocate regarding a client’s abilities and capacities, and they can advocate for their clients after an insurance or service denial. As with beneficence, the ethical duty of justice compels occupational therapy practitioners to take on the role of advocate.

“Veracity is based on the virtues of truthfulness, candor, and honesty. The Principle of *Veracity* refers to comprehensive, accurate, and objective transmission of information and includes fostering the client’s understanding of such information” (AOTA, 2015, p. 7). Veracity can be one of the most difficult elements of advocacy. Occupational therapy practitioners must be truthful in their presentation of a client’s abilities and capacities; they must be truthful in their application of rules, such as the medical necessity standard; and they must be truthful to their clients regarding the likelihood of success in achieving their goal. In sum, client-centered advocacy is an ethical responsibility of occupational therapy practitioners.

How to Be an Advocate

Recognizing one’s responsibility to provide advocacy for clients is very different from knowing how to provide that advocacy. In the United States, many laws protect and provide for people who need income support, health, or other services and define their rights. However, each law defines *eligibility*, *needs*, and other factors in a different way. Sometimes the definitions differ from the definitions used in occupational therapy education. Occupational therapy practitioners must learn how to find these laws and regulations and translate them into effective client education and advocacy. They must analyze them to the best of their ability to present an appropriate, valid picture.

For instance, *disability* is defined in many different ways. The World Health Organization (WHO; 2016) provided a key definition of *disability* as “an umbrella term, covering impairments, activity limitations, and participation restrictions,” noting that participation restriction is “a problem experi-

enced by an individual in involvement in life situations.” Thus, disability is “a complex phenomenon, reflecting an interaction between features of a person’s body and features of the society in which he or she lives.” This definition is good because it is inclusive and offers ample room to identify disability through an occupational lens. However, this embracing definition of *disability* is rarely fully reflected in U.S. federal or state legislation.

Another key definition of *disability* is outlined in the Americans With Disabilities Act of 1990 (ADA; Pub. L. 101–336):

As used in this chapter: (1) Disability. The term “disability” means, with respect to an individual (A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such impairment; or (C) being regarded as having such an impairment (as described in paragraph (3)). (42 U.S.C. 126, §12102[1])

Moreover, the ADA requires that interpretation favor broad and inclusive coverage. Occupational therapy practitioners must be aware what legislation governs the cause for which they are advocating to know which definitions are pertinent. The federal government has been given a greater role in the health care system through the Patient Protection and Affordable Care Act (ACA; Pub. L. 111–148, as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111–152]). This legislation and subsequent regulations implementing its many provisions affect access and delivery of health care services to millions of Americans.

Medical Necessity

One aspect of health care that will likely come into play in implementation of the ACA is the definition and implementation of *medical necessity*, a “key term in insurance companies’ coverage decisions [that] usually refers to the medical appropriateness of a particular intervention in a particular case” (Hill, 2012, p. 449). In other words, insurance companies and public programs use definitions of such terms as the basis for allowing or denying payment for or access to services. The ACA “contains no explicit definition of ‘medical necessity,’ nor does it

explicitly distinguish ‘medical’ from ‘non-medical’ interventions” (Hill, 2012, p. 450). Those who expected the ACA to force both public and private insurance to use a single, consistent definition of medical necessity have been disappointed. For this reason, the application of this abstract term to the delivery of health care “does not solve the question of how [health care providers] and insurers will make particular medical necessity determinations within these broader contexts” (MiraMed, 2013).

Under the ACA, medical necessity is interpreted in the context of the covered benefits. The ACA established 10 categories of essential health benefits (EHBs) that must be covered by individual and small group plans, but the U.S. Department of Health and Human Services (HHS) unexpectedly delegated the responsibility for defining the description and scope of those benefits to the individual states. States selected an existing insurance plan to serve as a benchmark and required the other plans to offer substantially equal benefits. This decision rooted implementation of the new ACA insurance in existing insurance programs, carrying forward negative practices as well as positive ones.

In October 2011, before HHS gave states the authority to use existing insurance guidelines, the Institute of Medicine (IOM; 2011) issued a report titled *Essential Health Benefits: Balancing Coverage and Costs* in an attempt to define medical necessity within the context of the ACA. The report said, “Only medically necessary services should be covered, and decisions by insurers about what is ‘medically necessary’ should depend on the circumstances of an individual case” (IOM, 2011, p. 3). The IOM report also emphasized that the ACA ensures that people who are denied care have a right to appeal the decision, and it acknowledged that many definitions of medical necessity currently exist but refused to select a single definition to apply to all ACA marketplace plans. Instead, according to Hill (2012), the report “embraced the view that [t]he central question is whether the treatment is medical in nature and whether the individual can be expected to medically benefit from it” (pp. 450–451). However, it did not de-

fine the central term *medical* or the equally important verb *benefit*.

The ACA was written in a manner that was cognizant of the need to define terms. It directed HHS to create a glossary of medical and insurance terms to help consumers compare and choose among health insurance plans. This glossary was not intended as a definition of coverage requirements for insurers—the benchmark plans were to provide those guidelines. The glossary defines *medically necessary* as

health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine. (Center for Consumer Information and Insurance Oversight, n.d., p. 3)

The definition was revised in April 2016 to clarify that *habilitative services*—health care services that help someone learn or maintain, rather than regain, a skill or function—can be medically necessary (U.S. Department of the Treasury, U.S. Department of Labor, & HHS, 2016).

As the ACA continues to develop and take form, occupational therapy practitioners must continue to explore the many existing definitions of medical necessity and advocate to improve them. For instance, Title 55 of the Pennsylvania Code (2016), in the state Medicaid statute, sets forth the following criteria for medically necessary services:

A service, item, procedure or level of care that is necessary for the proper treatment or management of an illness, injury or disability is one that:

- (1) Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- (2) Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- (3) Will assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into

account both the functional capacity of the recipient and those functional capacities that are appropriate of recipients of the same age. (§1101.21a)

Defining medical necessity does not end with legislative attempts. As shown in Table 1, many definitions exist, which have many similarities. For instance, all the definitions include the broad term *health care services* and have a focus on appropriateness. They also outline use of clinically accepted frequency and duration and discuss relationship of treatment to outcomes, or the reasonable expectation of outcomes.

Although language differences in each definition appear only incremental, they can have a profound effect on the delivery of occupational therapy services. For example, the American Medical Association (2011) definition refers to the practitioner as a *prudent physician*. This language is then adopted in the Cigna definition. This type of language can exclude occupational therapy practitioners from the determination of medical necessity, which in turn affects occupational therapy’s role in the delivery of health care.

Occupational therapy practitioners’ professional responsibility does not end with familiarizing themselves with existing definitions of medical necessity. Practitioners should work together to create, publish, and promote within AOTA and through federal and state laws and regulations a definition of medical necessity that fully encompasses clients’ needs. An expansive definition of the term would allow for broader occupational therapy services than the current definitions, which tend to focus on treatment to recover lost function. Although some definitions of medical necessity include concepts such as activities of daily living and functional capacity, they may still fall short of encompassing a client’s full needs as determined through completion of an occupational profile. An improved definition would include a unique marriage of the WHO’s (2016) definition of *disability*, the ADA’s stance on impairments and limitations, and occupational therapy’s perspective on

optimizing health by addressing a client's ability to fully participate in occupations. A perfected definition of medical necessity could blend multiple concepts, as follows:

Medically necessary health care services or products are those that a prudent health care practitioner would provide to a client who is experiencing an exacerbation or event that reflects an interaction between features of his or her body and/or psychological wellness and features of the society in which he or she lives; that limits one or more major life activities; and that affects daily life and major life activities, in a manner that is (1) in accordance with generally accepted standards of . . . practice and (2) clinically appropriate in terms of type, frequency, extent, site, and duration.

Occupational therapy can have a profound impact on major life activities as practitioners push for inclusion of client-centered definitions of *occupation* and other

terms in legislation, regulations, and, most important, daily practice.

Other Barriers to Coverage

Navigating the complex process of finding an applicable definition of medical necessity and applying it to a client's case is only the beginning of effective advocacy. For example, because the [ACA's] "market reform provisions effectively bar discrimination at the point of enrollment, efforts to constrain costs at the point of coverage and use become all the more important to understand" (Rosenbaum, Teitelbaum, & Hayes, 2011, p. 5). Certain terms such as *educational* or *social* have been used to exclude people from benefits under many insurance plans. The ACA may eventually have to be interpreted by the courts to explicate these types of limitations.

One way to respond to these cost-containment provisions is through a thorough determination of client need; this step relies on evaluation, including development of an occupational profile, and appropriate

and descriptive documentation throughout the client's treatment term. The first step usually involves analyzing a client's functional status. What is the client's age, education, and experience? In what activities can the client participate? In what work activities can the client participate? How do these activities differ from what the client was previously able to perform? What are the client's goals? How will function change with the requested interventions or equipment? The Social Security Administration uses domains to determine the existence of disability in a child; these domains can be useful in the determination of any client's needs or strengths across the lifespan. These domains include acquiring and using information, attending and completing tasks, interacting and relating with others, moving about and manipulating objects, caring for oneself, and health and physical well-being (Social Security Act of 1935, Pub. L. 74-271). Occupational therapy practitioners can apply these elements to all client documentation in health care and other settings.

Table 1. Definitions of Medical Necessity

Source	Definition	Citation
American Medical Association	Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.	American Medical Association (2011)
Consumer Glossary	Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine. ^a	Centers for Medicare and Medicaid Services (2016)
Cigna (Private insurance)	[H]ealth care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: A. in accordance with the generally accepted standards of medical practice; B. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and C. not primarily for the convenience of the patient or Physician, or other Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.	Cigna (2014)
Pennsylvania Code	Services are medically necessary if they meet one of the following standards: 1) the service or benefit will or is reasonably expected to prevent the onset of an illness, condition or disability, 2) the services or benefit will or is reasonably expected to reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability, 3) the service or benefit will assist the member to achieve or maintain functional capacity in performing daily activities taking into account the functional capacity of the member and those functional capacities that are appropriate for members of the same age.	Pennsylvania Medical Statute (2016)

^aThe definition was revised in April 2016 to clarify that rehabilitative services, health care services that help someone learn or maintain, rather than regain, a skill or function, can be medically necessary. See U.S. Department of the Treasury, U.S. Department of Labor, & U.S. Department of Health and Human Services (2016).

Value of the Occupational Therapy Perspective

An occupational perspective can be critical when arguing for certain services to be considered medically necessary. A case in which I was involved provides a good example. The Medicaid managed care insurance plan denied 12 night nursing hours because they were not deemed medically necessary. The child had been diagnosed with Down syndrome, autism, and a seizure disorder. At any time, she was at high risk for having a seizure that could harm her if not attended to appropriately and in a timely manner. She had continuous feedings by means of a tube and required intermittent oxygen. Additionally, the cords to the pulse oximeter to which she was connected at night could become wrapped around her neck. Monitoring her activity and the positioning of the cords was necessary for her safety.

The only rationale for denial was that the night nursing hours were not reasonable or medically necessary because the child's family members were available as live-in caretakers. I was called in to assist with defining a rationale for the need for night nursing. I performed an evaluation for each member of the family that included every occupation in which each member participated throughout the day for a week and an activity analysis that outlined the time spent in each activity. The focus included morning, after-school, and evening and nighttime routines and the amount of time required for each component of each routine. These analyses laid the foundation to support that, for each family member, every hour of the day was filled with a necessary occupation required to sustain the child's well-being. On the basis of these analyses, it was evident that the requested night nursing hours were necessary for the safety and care of the client because the other family members' time was needed for other activities, including sleep.

Services were eventually allowed to be covered for overnight. The argument that validated the necessity of services was focused not only on the child but also on the occupational profile of the child's family.

The distinct perspective of occupational therapy clarified the overall impact. For the family unit to survive, thrive, and be healthy and, therefore, for the child to survive, thrive, and be healthy, special attention and consideration had to be paid to the child's caregivers' other responsibilities in order to formulate a valid opinion on the medical necessity of the overnight services. The occupational therapy review went beyond simply the child's condition and thereby provided that perspective.

Occupational therapy practitioners must ensure that they distinguish between what services a client is eligible for and what the client actually needs. They must advocate on the basis of these needs, not just to provide services for the sake of providing services. Advocating for services without assessing actual need diminishes the credibility of practitioners' arguments and justifies payers' or policy-makers' efforts to restrict access to therapy services.

It is also imperative that occupational therapy practitioners include evidence-based research to support advocacy efforts. Throughout the many definitions of medical necessity, the recurrent theme is the appropriateness and effectiveness of the intervention. Because occupational therapy is an evidence-based profession, occupational therapy practitioners have excellent training in the use of research to confirm and authenticate their clinical reasoning. This research can include systematic reviews, randomized controlled trials, single-case experimental studies, qualitative studies, cohort and follow-up studies, and economic studies comparing all outcomes against costs. However, occupational therapy practitioners can expand their research to include nontraditional research. When necessary and applicable, practitioners can apply case law, legislative information, statutes, and regulations to the advocacy process. They can find cases with similar facts and an outcome that would benefit the client and demonstrate how the client's facts fit the elements of a statute or regulation. The occupational therapy practitioner should continue searching until the best evidence is located and applied to the client's cause.

Beyond Single-Client Advocacy

Although many practitioners may never be called upon to participate in a court case, most practitioners will endure the grueling process of writing appeals for medically necessary denials of occupational therapy services. Through these letters, practitioners will find the inclusion of evidence, whether scientific, legislative or policy, or anthropological, to be a useful and highly effective advocacy tool. Additionally, these letters can serve needs beyond one client to modify policies for an entire community's access to occupational therapy.

Occupational therapy practitioners have other ways to advocate beyond individual client services. They must also advocate at the legislative level. Throughout the creation and implementation of the ACA, occupational therapy practitioners have been given many opportunities to advocate for our profession, such as ensuring that occupational therapy is included in the EHBs. AOTA, our collective voice in legislative matters, was instrumental in achieving this inclusion (Metzler, personal communication, March 1, 2015). During the development of the ACA, AOTA successfully lobbied to have rehabilitative and habilitative services and devices included among the 10 EHBs, ensuring that millions of people enrolled in ACA plans would have access to occupational therapy services. By ensuring occupational therapy's presence in legislation and regulation, not only are we creating stronger support for client advocacy efforts, but we are also minimizing the need for individual advocacy by creating appropriate access to services.

Conclusion

The AOTA *Code of Ethics* (2015) and *Framework* (2014b) oblige occupational therapy practitioners to provide skillful, client-centered advocacy. As occupational therapy practitioner advocacy becomes more effective, it may result in linkages with legal and other fields and provide feedback to improve occupational therapy practice. This dynamic reduces inefficiencies and promotes justice for the clients whom occupational therapy serves, for people with disabilities, and for the public. ▲

References

- American Medical Association. (2011, January 14). *Statement of the American Medical Association to the Institute of Medicine's Committee on Determination of Essential Health Benefits*. Retrieved June 26, 2016, from <http://www.nationalacademies.org/hmd/~/media/8D03963CAEB24450947C1AEC0CAECD85.ashx>
- American Occupational Therapy Association. (2014). Occupational therapy practice framework: Domain and process (3rd ed.). *American Journal of Occupational Therapy*, 68(Suppl. 1), S1–S48. <http://dx.doi.org/10.5014/ajot.2014.682006>
- American Occupational Therapy Association. (2015). Occupational therapy code of ethics (2015). *American Journal of Occupational Therapy*, 69(Suppl. 3), 6913410030. <http://dx.doi.org/10.5014/ajot.2015.696S03>
- American Occupational Therapy Association. (n.d.). *Promote the profession: The brand*. Retrieved June 28, 2016, from <http://www.aota.org/AboutAOTA/Centennial-Vision/Brand.aspx>
- Americans With Disabilities Act of 1990, Pub. L. 101–336, 42 U.S.C. §§ 12101–12213 (2000).
- Center for Consumer Information and Insurance Oversight. (n.d.). *Glossary of health coverage and medical terms*. Retrieved from <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf>
- Centers for Medicare and Medicaid Services. (2016). *Departments finalize new version of the summary of benefits and coverage*. Retrieved from <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-04-06.html>
- Cigna. (2014). *Medical necessity definitions*. Retrieved from <http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>
- Health Care and Education Reconciliation Act of 2010, Pub. L. 111–152, 42 U.S.C. 1305.
- Hill, J. (2012). *What is the meaning of health? Constitutional implications of defining “medical necessity” and “essential health benefits” under the Affordable Care Act* (Case Western University School of Law Faculty Publications, Paper 81). Retrieved from http://scholarlycommons.law.case.edu/faculty_publications/81
- Institute of Medicine. (2011). *Essential health benefits: Balancing coverage and costs* [Report brief]. Retrieved June 28, 2016, from <http://www.nationalacademies.org/hmd/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost/Report-Brief.aspx?page=2>
- Merriam-Webster. (2016). Retrieved from <http://www.merriam-webster.com/dictionary/advocate>
- MiraMed. (2013). Medical necessity and the Affordable Care Act. Retrieved June 24, 2016, from <http://www.mirameds.com/ealerts/104-medical-necessity-and-the-affordable-care-act>
- O'Toole, C. H. (2014). The new social justice. *Pitt Law Magazine, Fall*, 8–15.
- Patient Protection and Affordable Care Act, Pub. L. 111–148, 42 U.S.C. §§ 18001–18121 (2010).
- Pennsylvania Medical Statute. (2016). *Public welfare*. 55 Pa. Code § 1221.21a (relating to scope of benefits for the categorically needy). Retrieved June 24, 2016, from <http://www.pacode.com/secure/data/055/chapter1101/s1101.21a.html>
- Rosenbaum, S., Teitelbaum, J., & Hayes, K. (2011). *The essential health benefits provisions of the Affordable Care Act: Implications for people with disabilities* (Commonwealth Fund Pub. 1485, Vol. 3). New York: Commonwealth Fund.
- Social Security Act of 1935, Pub. L. 74–271, 42 U.S.C. §§ 301–1397mm (1935).
- U.S. Department of the Treasury, U.S. Department of Labor, & U.S. Department of Health and Human Services. (2016). *Glossary of health coverage and medical terms*. Retrieved from <https://www.dol.gov/ebsa/pdf/SBC-Uniform-Glossary-final.pdf>
- World Health Organization. (2016). *Disabilities*. Retrieved June 24, 2016 from <http://www.who.int/topics/disabilities/en/>