Guidance on Billing and Reimbursement for Athletic Trainers

This document is intended to serve as guidance for athletic trainers, employers, and insurers specific to recommended billing and reimbursement practices for athletic trainers who deliver physical medicine and rehabilitation (PM&R) services and desire to seek reimbursement from an insurer for selected services. It is intended to help define to all stakeholders what the NATA philosophically supports, and what the NATA supports from a resource perspective.

The NATA and subsequently, the NATA Third Party Reimbursement Initiative, has placed a priority on efforts that advance transparent autonomous billing as an athletic trainer under consult or referral of a physician, or other allowable provider under state law. Athletic trainers desire to be reimbursed consistently with other allied health providers. For this reason, the NATA philosophically recommends that athletic trainers bill from a process and policy perspective consistent with other allied health providers that are reimbursed by insurers for PM&R services. While athletic trainers are not currently recognized as providers by the Centers for Medicare and Medicaid Services (CMS), the NATA recommends athletic trainers practice in alignment with Medicare policies when they seek reimbursement from payors of all types. These policies, defined for other allied health providers, are detailed in Chapters 12 and 15 of the Medicare Benefit Policy Manual for physical therapy (PT) and occupational therapy (OT) services. The following guidelines, therefore, are consistent with current Medicare program requirements and are recommended for athletic trainers' work across all settings.

Because the NATA is supportive of efforts that align with services rendered in accordance with Medicare policy and process, the NATA currently resources advancement of these efforts from a philosophical, financial, advocacy and educational perspective. It does not resource efforts that fall outside of this philosophy at this time. The NATA cannot control for all billing activity, but strongly hopes to align any billing processes around CMS guidelines to the greatest extent achievable regardless of setting.

The NATA does recognize that some but not all employers and payors desire to follow Medicare policy strictly, but that variance does exist.

Additionally, the NATA recommends that the employer and/or health care attorneys that have a deep experience with billing compliance perform a thorough a regulatory and compliance review. Legal review should address employment structure, federal, and state regulatory and practice act considerations. This type of review is especially critical due to the emerging nature of billing for athletic training services and due to variances in athletic training state practice acts.

The NATA also asserts that all billable activity is delivered within the scope of practice of the respective state where the services are delivered.

I. GENERAL BACKGROUND

What is an Athletic Trainer (AT)?

As stated in the *Athletic Training Services: An Overview of Skills and Services Performed* 2 *by Certified Athletic Trainers (2010),* athletic trainers (ATs) are health care professionals who collaborate with physicians to optimize patient and client activity and participation in athletics, work and life. The practice of athletic training encompasses the prevention, examination and diagnosis, treatment, and rehabilitation of emergent, acute, subacute, and chronic neuro-musculoskeletal conditions and certain medical conditions in order to minimize subsequent impairments, functional limitations, disability, and societal limitations.

What is the Scope of Practice for ATs?

The Athletic Training Scope of Practice is defined within two professional publications: the Athletic Training Educational Competencies (Competencies) published by the National Athletic Trainers' Association (NATA) and the Role Delineation Study (RDS) conducted and published by the Board of Certification, Inc. (BOC). Eligibility for the BOC exam is contingent upon completion of a program accredited by the Commission on Accreditation of Athletic Training Education (CAATE) that must instruct the Competencies within the curriculum. Passage of the certifying examination is a requirement to become a licensed athletic trainer (LAT) in 49 states[1].

What settings are appropriate for practicing ATs?

Athletic trainers' work settings can include high schools, colleges, universities, professional sports teams, hospitals, rehabilitation clinics, physicians' offices, corporate and industrial institutions, the military, and the performing arts. Regardless of their practice setting, athletic trainers must practice in accordance with their education and state practice act.

Who recognizes ATs as health care providers?

The Centers for Medicare & Medicaid Services (CMS) provides a discrete National Provider Identifier taxonomy for LATs as part of the National Plan and Provider Enumeration System. However, athletic trainers are not recognized as providers by CMS.

The American Medical Association (AMA) formally recognized LATs as allied health care professionals in 1990 and it includes codes specific to athletic training evaluation and re-evaluation services in the AMA Current Procedural Terminology 2017 Professional Edition Codebook.

Athletic trainers are eligible for credentialing through the Coalition for Affordable Quality Healthcare (CAQH).

A growing number of commercial and capitated (HMO) insurance plans recognize PM&R services delivered by athletic trainers and will reimburse accordingly. Workers' Compensation payors recognize athletic training nearly universally.

[1] The state of California does not require athletic trainers to be licensed professionals.

II. RECOMMENDED BILLING STANDARDS AND GUIDELINES
Autonomous Physical Medicine and Rehabilitation Based Billing

Medical Necessity Must be Established

Whether or not certain services are covered is dependent upon medical necessity. Medicare defines "medical necessity" as the "healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine." Determinations of coverage may also vary based on a CMS National Coverage Decision (NCD) or Local Coverage Determination (LCD) made by Medicare Administrative Contractors (MACs). MACs may provide coverage only for those services that are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."[2] Athletic trainers should be familiar with and practice in accordance with the determinations of medical necessity and within the scope of their state practice act.

Chapter 12 Section 220.2 of the Medicare Benefit Policy Manual provides a list of conditions that are representative of the requirements to demonstrate reasonable and necessary services. Below is a brief summary of the requirements for demonstrating medical necessity that are in accordance with Medicare policies. Please refer to the Medicare Benefit Policy Manual for a full description of the requirements to determine reasonable and necessary services.

Establishing Medical Necessity for Rehabilitative Therapy

Rehabilitative therapy includes services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. Therefore, evaluation, re-evaluation and assessment documented in a Progress Report should describe objective measurements which, when compared, show improvements in function, decrease in severity or rationalization for an optimistic outlook to justify continued treatment. Improvement is evidenced by successive objective measurements whenever possible.

If an individual's expected rehabilitation potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, then the rehabilitative therapy or so called "maintenance therapy" is not reasonable and necessary.
Rehabilitative therapy services are skilled procedures that may include, but are not limited to:

- Evaluations and re-evaluations;
- Establishment of treatment goals specific to the patient's disability or dysfunction and designed to specifically address each problem identified in the evaluation;
- Design of a plan of care addressing the patient's disorder, including establishment of procedures to obtain goals, determining the frequency and intensity of treatment;
- Continued assessment and analysis during implementation of the services at regular intervals;
- Instruction leading to establishment of compensatory skills;

[2] 42 U.S.C. § 1395y(a)(1)(A).

- Selection of devices to replace or augment a function (e.g., for use as an alternative communication system and short-term training on use of the device or system); and
- Training of patient and family to augment rehabilitative treatment. Training of staff and family should be ongoing throughout treatment and instructions modified intermittently as the patient's status changes.

Rehabilitative therapy may be needed, and improvement in a patient's condition may occur, even when a chronic, progressive, degenerative, or terminal condition exists. Rehabilitative therapy is not required to effect improvement or restoration of function when a patient suffers a transient and easily reversible loss or reduction of function.

Documentation Standards

Proper documentation serves to provide a complete, accurate, and timely record of a patient's complete medical history. Proper recordkeeping also will facilitate communication and help to ensure a consistent level of care among and within multiple caregivers across various settings and incorporating best practices for documentation may serve to minimize the risk of malpractice for the AT and their employer in the event of litigation.

To be payable, the medical record and the information on the claim form must consistently and accurately report covered therapy services, as documented in the medical record. Documentation must be legible, relevant and sufficient to justify the services billed.

Chapter 12 Section 220.2 of the Medicare Benefit Policy Manual provides a list of the minimum requirements for documentation on submitted claims for therapy services. Below is a brief summary of the requirements for documentation in accordance with Medicare policies. Please refer to the Medicare Benefit Policy Manual for a full description of the requirements to determine reasonable and necessary services.

List of required documentation for rehabilitation therapy services

The following types of documentation for therapy services are expected to be submitted in response to any requests for documentation, unless the insurer requests otherwise. The timelines reflect the minimum required by Medicare. The clinician's judgment may dictate if more is required, but it should be no less than the frequency required in Medicare policy:

- Evaluation and Plan of Care (may be one or two documents). Include the initial evaluation and any re-evaluations relevant to the episode being reviewed.
- Progress Reports (including Discharge Notes, if applicable) when records are requested after the reports are due.
- Treatment notes for each treatment day (may also serve as progress reports when required information is included in the notes).
- A separate justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the insurer

understands their reasoning for services that are more extensive than is typical for the condition treated. A separate statement is not required if the record justifies treatment without further explanation.

Billing with CPT Codes

CMS uses the CPT coding system to establish reimbursement to Medicare providers. The CPT coding system describes medical, surgical, and diagnostic services performed by physicians and other health care professionals. The coding system, developed and maintained by the AMA, offers health care providers "a uniform process for coding medical services that streamlines reporting and increases accuracy and efficiency." The AMA includes four CPT codes for athletic training evaluation: 97169, 97170, 97171, and 97172.

- 97169 Athletic Training evaluation, low complexity
- 97170 Athletic Training evaluation, moderate complexity
- 97171 Athletic Training evaluation, high complexity
- 97172 Athletic Training re-evaluation

The level of the athletic training evaluation performed is dependent on clinical decision-making and the severity of the patient's condition, in conjunction with the level and complexity of co-morbidities that exist.

Athletic training evaluations include a patient history and an examination with the development of the plan of care.

Coordination, consultation, and collaboration of care with physicians, other qualified health care professionals, or agencies is provided consistent with the nature of the problem(s) and the needs of the patient, family, and/or other caregivers.

At a minimum, each of the following components must be documented in order to report the selected level of athletic training evaluation. Athletic training evaluations include the following components:

- History and physical activity profile
- Examination
- Clinical decision making
- Development of plan of care

For a comprehensive guide of other PM&R CPT codes and commonly used modifiers most often used in clinical practice by LATs please refer to the NATA fact sheet.

Dependent upon the employer, it is appropriate for an athletic trainer to bill using their own NPI number or an established facility NPI number.

It is recommended that an employer charge the same amount for the athletic training evaluation and subsequent codes that they have assigned when a PT or OT delivers the same services.

Physician-Based Billing

If an employer of an athletic trainer decides to bill for AT services under a physician NPI number, the NATA recommends that employers also align with the Medicare policy and process defined as "Incident-to" billing. Once again, the NATA recognizes that some employers and payors desire to follow Medicare policy strictly, but that variance does exist.

Across various health care settings, insurers' requirements for physician based billing may vary. Where some may pay for services furnished "incident to" a supervising physician's professional services, others may allow for billing under a physician's standing orders. "Incident to" is a CMS term and does not necessarily apply to all payor decisions. Although athletic trainers are not recognized by CMS as an "incident-to" provider, commercial payors may allow for athletic trainers to be reimbursed when billing for certain services in conjunction with a physician visit.

Billing under physician standing orders is currently not recognized or paid for by Medicare. The following information is, therefore, consistent with authorized providers who bill "incident to" under Medicare[3]. If billing under a physician NPI number, we recommend reviewing the commercial insurer's policy manual and verify their policy.

CMS defines "Incident to" services as those that are furnished incident to a physician's professional services whether in the physician's office or in a patient's home. These services may also include services supervised by certain non-physician practitioners such as physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, and clinical psychologists. These services are subject to the same requirements as physician-supervised services. [4]

To qualify as "incident to," services must be part of the patient's normal course of treatment, during which a physician or qualified non-physician practitioner personally performed an initial service and remains actively involved in the course of treatment. The supervising physician does not have to be physically present in the patient's treatment room while these services are provided but must be present in the office suite or facility to render assistance, if necessary. The patient record should document the essential requirements for incident to service including that the service is:

- An integral part of the patient's treatment course;
- Commonly rendered without charge (included in your physician's bills);
- Of a type commonly furnished in a physician's office or clinic (not in an institutional setting); and
- An expense to you.

The processes for billing may also vary depending on the care site and therefore should be confirmed with the insurer's policy.[5]

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[3] Medicare does not currently permit athletic trainers to bill "incident to" supervising physicians. Certain providers can bill "incident to," and those requirements are considered a model for billing practices.

[4] (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf)

[5] Id.

Additional Resources:

1. NATA's Best Practice Guidelines for Athletic Training Documentation

2. NATA's Billing 101 Fact Sheet