

Dealing with Reimbursement Denials



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Unfortunately, receiving notice from an insurance company that a claim has been denied for services is something we all will face as athletic trainers who are pursuing reimbursement for clinical rehabilitation services. As the Third Party Reimbursement Project gains momentum regionally and nationally, we hope to see “Denial of Services” decrease over time, as our profession is recognized as a qualified health care professional by insurance companies/payors in the clinical rehabilitation setting.

Until then, there are steps to take when dealing with a denial of services claim for athletic training services. While what is outlined in this chapter is certainly not exhaustive, it does give an athletic trainer and their billing/collection personnel some ideas on how to work through an appeal process.

1. Common reasons for denial of insurance claims

• **Lack of Preauthorization**

Some insurance companies require a preauthorization before administering services; you must identify the insurance companies that require a preauthorization process. This means that before treatment can be rendered in the rehabilitation setting, the insurance company wants information up front regarding the diagnosis and plan of care. This often is the culprit of the denial of services in the rehabilitation setting. *If not preauthorized, the claim will be denied.*

- This process often requires in advance of treatment:
 - Patient name, DOB, Member number.
 - National Provider Identifier (NPI) number (usually facility number).
 - Diagnosis (ICD-10 Code/s).
 - Name of Rehabilitation office, Rehabilitation Discipline (PT/OT/AT).
 - Phone and/or fax number.
 - Date of initial evaluation.
 - Details justifying rehabilitation.
 - Initial evaluation findings, symptoms, detailed plan of care.

• **Documentation**

The Evaluation and/or Plan of Care was incomplete.

- Evaluations should be descriptive, detailed, and have a purpose.
 - Service must be medically necessary.
 - Outlines justification for skilled intervention.

- Identifies the physical limitations and explains why rehabilitation is necessary. Documentation must support why the provider should be reimbursed for the service.
- **Improper Diagnosis Codes (ICD-10)**
 - Does the code correspond to the treatment?
- **Referral is not signed by the referring provider**
- **Patient is out of the Insurance Company's network for rehabilitation**
- **Member had previous services for the same diagnosis at another rehabilitation facility**
- **Services provided by an athletic trainer not recognized or covered by Insurance Company**
 - 97005 Evaluation/97006 Re-Evaluation not covered.*

**This is the most common reason for denial of AT rehabilitation services.*

2. What to do when you learn that athletic training is not a covered service by the insurance company or that the insurance company has covered athletic training services in the past, but now is denying the claim

The next step is to **Request an Appeal of the Denied Service**. Each insurance company has a different process for dealing with a denial of service(s):

- Some may take your request in writing; sending you a form or template to provide them with the information needed to proceed with the appeal process. Each insurance company has different language and forms for this process.
- The appeal process may be web-based. Each insurance company uses its own format to request medical information pertaining to a claim.
- Others may deal with the appeal verbally, offering you a "peer to peer" discussion, allowing you to "plead" your case and justify why your skills as a rehabilitation specialist are needed.
- *Whether this is in a written format, web-based or given verbally, this is the opportunity to sell yourself as a qualified health care provider and why you, as an athletic trainer, should be reimbursed for the rehabilitation services you are providing for your patient.*

3. The following ideas can be utilized to educate the insurance company and help to *justify* payment for your services. These should be individualized to your audience and your state.

- Athletic training has been recognized by the American Medical Association (AMA) as an allied health care profession since 1990.
- Numerous commercial and Worker's Compensation payors recognize athletic training services and reimbursement for those services.
- The health care administration supports the use of athletic trainers in the rehabilitation setting, as it improves **access** to treatment of the insured.
 - Stress the importance of **timely access** to rehabilitation services.
 - If there only is a PT/OT in a rehabilitation facility, this may work to delay or deny this patient from receiving **timely access** to care.
- Negotiate/Recommend the insurance company "trial" reimbursement for athletic training services for this client. Explain this will ensure the care is done promptly, and/or is not disrupted by having to "wait" for an evaluation with another rehabilitation discipline at your facility.

- Explain that a denial of athletic training services can be viewed as a disservice to the patient. The orders for this client were for “athletic training” services as signed by the referring provider.
- There is tremendous support by employers and patients for athletic training services.
- There has been no concern for the quality of care received by athletic trainers.
- Stress the use of an athletic trainer will NOT drive up the costs for services. If rehabilitation services are provided in the insured client’s benefit contract, athletic trainers utilize the same CPT codes (with the exception of 97005/97006) and are priced in line with PT/OT services.
 - 97005/97006 evaluation/re-evaluation codes also are priced in the same fee structure as PT/OT.
- The quality of care received by an athletic trainer is consistent with the other disciplines as demonstrated by outcome data collected in the Third Party Reimbursement Project.
- Demonstrate that your clinic will appropriately align patients with the clinical professional suited to provide the highest quality of care for the insured.
- Suggest to your referring provider that he or she send a letter to the insurer, requesting your services be covered.
- Ask for contact information and open communication with the Medical Director of the Insurance Company to review/discuss reimbursement for athletic trainers performing rehabilitation.
- Finally, suggest to your patient he/she contact to the insurance company, as a customer, and request reimbursement for athletic training services. In the end, the patient is who the insurance company serves.

None of this will guarantee the Insurance Company will reimburse the athletic training services. However, by continually requesting these services be covered, your request will continually be referred to the next level of “decision makers” within the insurance company, which brings athletic training services to the forefront of their meeting agendas.

Be professional and courteous when dealing directly with payors. Your initial interaction often lays the foundation for future consideration of reimbursement. Accept a “No” if that is their final decision and thank those that took the time to speak with you. Then request further dialogue with the medical director of the insurance company and offer to answer any questions about licensure, education, knowledge, and skills that an athletic trainer possesses. Finally, bring your interaction and results to the attention of NATA staff. The contact information is listed below. NATA staff can proceed to make contact with the insurance company and assist in keeping them informed of the trends in reimbursement for athletic training services in the rehabilitation setting while continuing to request reimbursement for athletic trainers.

Visit [nata.org](https://www.nata.org) for more information on Practice Advancement.

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