National Athletic Trainers Association
Online Reimbursement Manual

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Reimbursement is an issue that is complex and involved. Obtaining reimbursement at most levels will take a concerted effort from individual members, NATA and interested groups.

The “paying” field is large and contains many payers. Neither one person nor a committee can cover it all.

We must educate ourselves on reimbursement and third party issues. We need to understand the reimburser’s mindset while educating the public and healthcare personnel to the benefits and roles athletic trainers can play in the healthcare system.

We need to develop data, maintain records and factual information on positive outcomes, so we may more easily demonstrate our value as health care providers.

The reimbursement issue is like a spider web. Acknowledgement that Certified Athletic Trainers are like any other affiliated health care provider when it comes to reimbursement is the open center of the web, the strands and the sections of the web are the paths and sometime sticky situations we must traverse to reach our final destination.

This manual will provide you with the basic terminology and “how to” information on reimbursement. See the included links for more detailed information.
You may use this manual to chart your course and avoid or overcome any bumps in the road that may await your efforts.

NATA Council on Revenue

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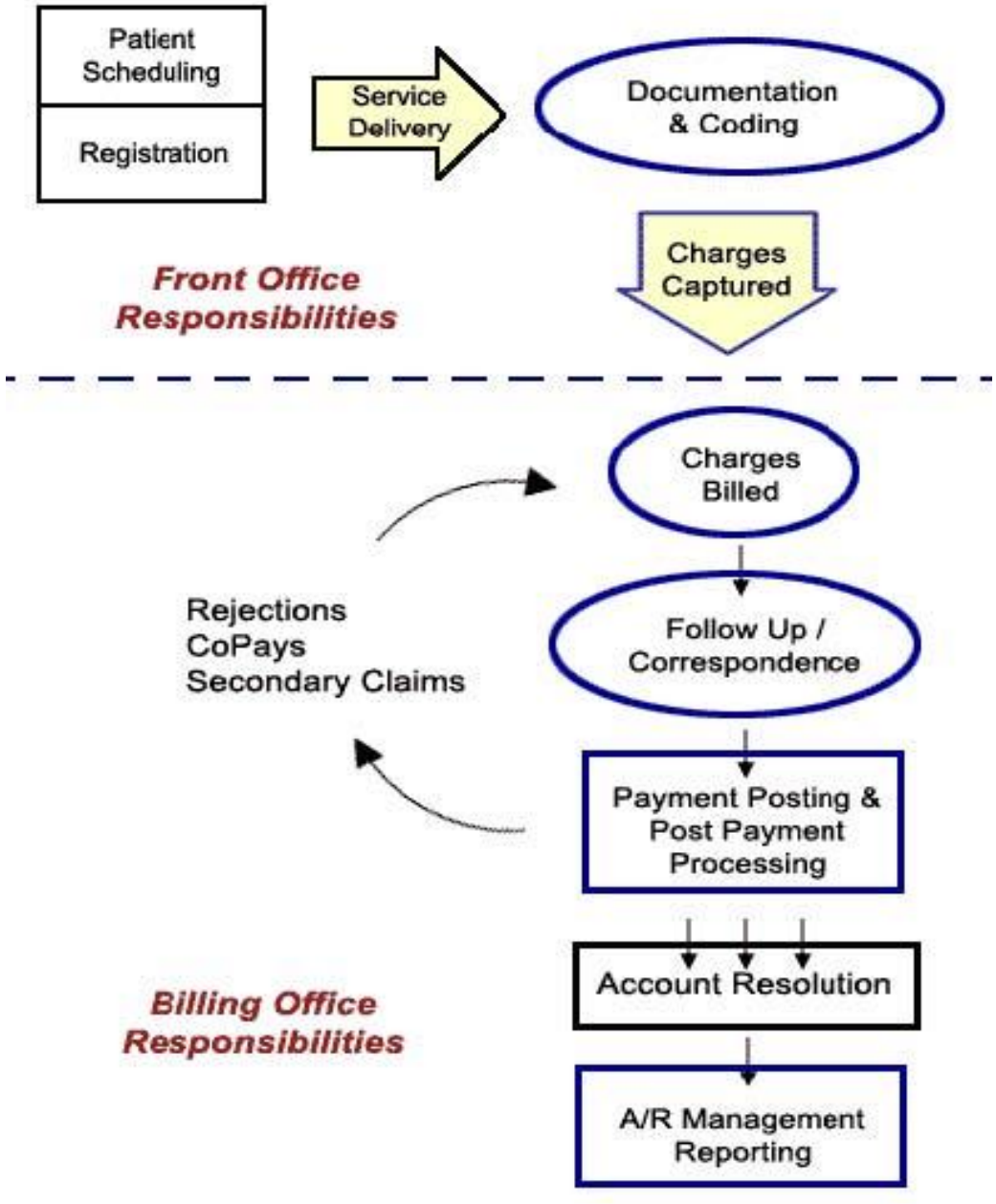
Billing Cycle



Section 1

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The Payers

According to an American Medical Association survey conducted in 1999, 30% of all employees' health care was covered by an HMO, 11% was covered by indemnity or traditional insurance, 16% by a POS program and 43% by a PPO.

Insurance is the term widely used to identify all types of third party payers. It is an incorrect usage. There are a number of payers, each with their own peculiarities. In this section we will identify and discuss each one.

Insurance-The definition of insurance in its simplest form is "the relief from the burden of financial loss." Health insurance provides reimbursement or indemnifies an insured from financial losses resulting from covered perils, after the loss. Deductibles and co-insurance payments normally apply to covered conditions in a health insurance policy. These are the patient's responsibility. Traditional insurance is sometimes called FFS or Fee For Service insurance.

Managed Care-Managed Care is a term loosely used to describe everything from HMOs to traditional insurance. Almost all programs that use any type of utilization controls over reimbursement or benefits can be classified as Managed Care.

HMO-Health Maintenance Organizations have been around in various forms for more than 100 years. The prepayment of health care providers for services they may or may not render is not new; the year 1929 saw the first "modern" version of an HMO. The Ross Loos plan in Los Angeles has been credited with being the first modern HMO. Other HMO organizations followed and adaptations and changes have been significant. The basic idea of an HMO was to limit the providers that a member could access, pay those providers a reduced fee, normally in the form of capitation, and have other systems in place to control "unnecessary" procedures and expenses. The basic forms that HMOs take are, staff model, IPA model, group model and network model. Normally there are no deductibles for the members but there are co-payments to be paid at time of service.

PPO-The Preferred Provider Organization is a less restrictive access method for providing health coverage. In place of not paying for a claim that is "out of network" the PPO penalizes you, monetarily, for not using the company's Preferred Providers. There are normally co-payments/co-insurance costs for using preferred providers, and larger deductibles, and higher co-insurance/co-payments for using non-preferred providers. Hospital deductibles and co-insurance payments are usually required when using a PPO; the same theory applies, higher out of pocket costs to the member for choosing to use non-preferred providers.

EPO-Exclusive Provider Organizations are a variation on the HMO/PPO theme. These organizations would like to be viewed as being similar to PPOs, however the majority of them are very restrictive in the number and types of providers they have paneled, and consequently are more closely aligned with a closed panel HMO. Most will not pay anything if you use "out of network" providers. Deductibles/co-insurance/co-payments may apply.

These organizations are rare. TOC

POS-Point of Service, this plan is a hybrid. The simplest explanation is a POS plan combines an HMO with a PPO and the member can chose which plan they will use at the point or time of service. The normal restrictions apply per the plan chosen for use.

PHO-Physician Hospital Organization is a combination of a major hospital or hospital chain and its admitting physicians. This allows the PHO organization to contract directly with employers to provide services and/or contract with a Managed Care organization sometimes under more favorable terms than contracting with a Managed Care organization individually. PSO (Physician Service Organization) is a Federal designation given when a PHO accepts capitation for services rendered to enrolled Medicare beneficiaries.

TPAs-Third Party Administrators, come in many forms and are employed for a number of reasons. Most frequently they are used to administer services and to pay claims for self-insured group plans. In this capacity they become pseudo insurance companies. They can perform the gambit of services such as member services, enrollment and billing and assist with controlling utilization without the financial risk.

The Blues Organization-Blue Cross/Blue Shield and other named entities are part of the 43 member Blues Organization. Blue Cross is the Hospital organization and Blue Shield is the Physicians program. The Blues were traditionally non-profit but in the last few years a number of the plans have moved to a for profit status. Today the lines differentiating the Blues companies and traditional insurers/managed care companies are blurred. For purposes of reimbursement the Blues should be considered in the same manner as a more traditional insurance/managed care organization. The Blues are listed separately as they have been viewed as service organizations and not seen or even regulated in the same way that insurance companies are. The Blues can be separate organizations, Blue Cross vs. Blue Shield, but more commonly they have merged and are now one. The various Blue plans have separate HMOs that work with or in conjunction with their more traditional programs. The traditional BC/BS program has participating providers and non-participating providers. The participating providers are usually paid directly, and are in agreement to accept the BC/BS fee schedule as payment in full.

Medicare-Is the Federal health insurance program for the aged, disabled and those requiring kidney dialysis. Most people at retirement age qualify for Medicare benefits. There are two parts or sections to Medicare, part A the hospital portion is normally premium free at retirement to the beneficiaries. Part B is the physician section and there is a monthly premium charge to the beneficiary. The monthly premium for part B changes annually. There are also deductibles and co-insurance percentages/amounts that are paid by the beneficiary under both part A and part B. Athletic Trainers are not allowed to bill Medicare for services rendered to a Medicare beneficiary.

Medicaid-The health insurance program for people with low incomes and limited resources. Both the federal government and the states fund Medicaid with the state responsible for handling the administration of the program. Benefits vary by state. The claim payers can be a contracted entity or the state. Any willing provider is the standard network model for Medicaid.

SCHIP/CHIP-State Children's Health Insurance Program. SCHIP is a State and Federal program for uninsured and low-income children. SCHIP is similar to Medicaid but sometimes with a broader range of benefits and easier participation or admittance requirements. The claim payers can be a contracted entity or the state.

Tricare/Champus-Tricare is the Defense Department's regional managed health care program. Tricare has three plans, Tricare Prime is similar to an HMO, Tricare Extra which has an expanded network and can be used at the point of service (think POS) and Tricare Standard which works in a similar fashion to Champus (think traditional insurance). Champus or Tricare standard allows more freedom to participants but with higher out of pocket costs.

MACs are the Medicare Part A and Part B claim payers and adjudicators. Carriers are contracted with Centers for Medicare and Medicaid Services, CMS, to pay and adjudicate Part B (physician services, PT, OT and other services) claims. Durable Medical Equipment claims are handled by Regional Carriers, known as DMERCs (Durable Medical Equipment Regional Carriers). RHHIs are Regional Home Health Intermediaries; they are the contracted fiscal intermediaries that specialize in processing home health and hospice claims. All intermediaries/carriers can be insurance or managed care organizations; various Blue Cross/Blue Shield organizations hold a number of these contracts.

Workers Compensation-The laws and benefits for injured workers are mandated by the states through workers compensation commissions. Though the benefits are mandated by the states, employers pay the premiums and the claims are adjudicated by Workers Compensation Insurance Carriers. The insurance companies that specialize in this program have a financial interest in returning injured workers back to the work force as soon as practical.

Private Automobile Insurance-A patient could seek treatment from an injury caused by an auto accident, this claim may be covered by automobile insurance.

Cash-There is nothing wrong with accepting cash for services rendered. Good old American greenbacks are still legal tender. Accepting cash and allowing the patient to bill their carrier for reimbursement removes the burden from the Certified Athletic Trainer and places it with the person who has the most influence with their carrier, the member or patient. Before you start to accept cash/charge cards/checks, you must set up a system for handling the cash and issuing receipts. A check verification program may be one service that you wish to investigate. You also must become associated with the various charge companies whose cards you will be accepting; there is a fee for accepting credit cards. All of this can take time, energy and resources. Be prepared.

MSA- Medical Savings Accounts, tax deductible, direct access to funds, must be in conjunction with a high deductible health plan.

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FSA- Flexible Spending Accounts, subject to use it or lose it rule at the end of the plan year, funds are tax deductible, no restriction on type of health plan

HSA- Health Savings Accounts, tax deductible, direct access to funds, must be in conjunction with a high deductible health plan. Any employers or individuals under 65 with qualified plan.

Certified Athletic Trainers, can bill directly to third party payers, citing your own contract or provider number. Certified Athletic Trainers can also have their services billed "incident to". That term is used to designate a procedure performed incident to working with a physician, also in some cases a PA or NP. Under incident to billing the claim is submitted as though the physician had performed the procedure(s). Most third party payers reimburse for incident to procedures. Prior to a recent change in Medicare's policies, Certified Athletic Trainers could perform a procedure and have the physician bill for those services under incident to for Medicare patients. Right now only non-therapy services performed by an Certified Athletic Trainer can still be billed under "incident to" criteria for Medicare patients. For most other third party payers all services provided, incident to a physician, can be billed incident to. This can be confusing, if you have any questions about incident to billings and procedures please contact Patty Ellis at NATA. pattye@nata.org or by phone @ 972-532-8833

Section 2

Contracting

In this section we will discuss, in brief detail, contracting with payers, how to and what to look for. These few paragraphs cannot hope to make you a contracting guru, but they may provide you with enough information to ask the right questions.

Capitation-Capitation has gotten a bad rap; it is not a bad method, and is still used by some Managed Care HMO entities. Simply, in capitation the provider is paid a set fee per member assigned, per month (PMPM). The amount paid varies with specialty, need and practice size. For example, a typical therapy practice that is handling 10,000 members may receive .50 cents PMPM. That equates to $5000 per month! Each and every month you are contracted under this arrangement the practice would receive the $5000. Whether any patients are seen or whether all 10,000 are seen, the practice receives the same $5000. The idea behind this arrangement is it gives the providers an incentive to manage their patients

and to maintain their health. TOC

Case Rate-A fee negotiated for a particular case or course of treatment.

Reduced Fee For Service-Undoubtedly the most variable of the contracting methods, you produce a fee schedule for the services you may render, the carrier then negotiates from that schedule. The fee schedule could be 100% of normally charged fees or any variation from that.

RBRVS-Resource Based Relative Value Scale, this is the system and fee schedule under which almost all provider bills are adjudicated for Medicare. This scale or payment rate is reviewed by CMS at least every 5 years. Numerous organizations use RBRVS as the starting point for payment, they may adjust up or down from this scale. You will commonly hear, "We pay 100% of RBRVS" or "We pay 90% of Medicare" (same as RBRVS). The AMA conducted a national survey that showed 63% of respondents were using RBRVS for at least one product line, a Deloitte-Touche survey found that 72% of respondents were using or intended to use RBRVS and with the BC/BS organizations that percentage jumped to 87%. RBRVS is not the only value scale used, there are others so be cognizant of what scale a carrier is using and what year it was implemented.

Full Risk Contract-A contract where the provider group assumes the entire financial risk of caring for the members, this is done in exchange for a set fee PMPM similar to capitation. This arrangement includes any and all covered service(s). The contracting provider group would need to sub-contract for any specialties or services that their practice cannot handle.

These are the basic contracting models; there are variations from these.

How do you start the contracting process? First make certain that you wish to be contracted. Traditional insurance programs and non-managed care entities normally do not require contracts. They usually pay Usual, Customary and Reasonable, UCR, charges from any recognized health care provider operating within their license and Scope of Practice. If you do wish to go further and actually contract with carriers there are some first steps:

• Contact the carrier, normally the first contact is with a Provider Representative, this person may have limited contracting discretion if any. They can and will carry your message back to the Manager or Director of the unit. Occasionally the lead person of this unit is the Medical Director but normally it is a non-medical person. This unit does defer to the Medical Director for any medical services that are unknown to them, you may have to present your case to both the medical Director and the Contracting Director.

• If you have decided to move forward with trying to contract with a carrier, you

need to ascertain if they recognize Certified Athletic Trainers as allied health care professionals. If not then you have to fight the battle to have Certified Athletic Trainers recognized first.

• Assuming they do acknowledge that Certified Athletic Trainers are a reimbursable health care profession, you must begin to think like the payer. You must ask yourself, why? Why should they add an Certified Athletic Trainer or a clinic to their panel of providers? What value do you bring to that carrier? Remember that for the most part, the insurance/managed care organizations primary concerns are costs/profits. How do they minimize the costs and maximize the profits? That is primary, providing care for the members is sometimes a secondary consideration.

• You will need to meet with the Provider Representative and propose your availability to contract. Let the carrier raise or bring their objections to you. Ask for clear and precise reasons why they will not consider contracting with Certified Athletic Trainers. In one state the BC/BS organization has stated that they have no desire to contract with any Certified Athletic Trainers. They feel that their current providers are already handling any covered service that an Certified Athletic Trainer can provide. (MDs, PTs, OTs, Chiros etc.)

• In most managed care programs the fewer the number of providers, the more cost effective the plan is. Why should they wish to add additional providers if the members are currently receiving the care they require? That is the question that you need to develop an answer(s) for, answers that will impact the carrier and their cash position positively. What does an Certified Athletic Trainer offer that would convince a payer to offer them a contract, better outcomes? If so, how does this translate into a benefit for the carrier? How do we "prove" we have better outcomes?

Some common paragraphs used in managed care/insurance contracts that you need to be aware of:

Hold Harmless Clause-This clause stipulates that if the contracted party does not reimburse you for covered services you have no right to bill or expect payment from the patient. This even includes the carrier going out of business. You are specifically prohibited from billing the members for any amount other than copayments/co-insurance or non-covered services.

Gag Clause-A clause that may prohibit contracted providers from discussing alternative treatments, experimental treatments and costs. May also bar you or limit you from sharing other information with a member or patient. A number of states have laws prohibiting companies from including the Gag Clause in their contracts.

Favored Nation Clause-This clause stipulates that you cannot contract with any other carrier (s) on a more favorable basis. If you do then the clause allows the first carrier the same options and rates.

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Exclusivity Clause-If this clause is included in the contract you are prohibited from contracting with any other like entity.

Mandatory Time Limit on Claims -A clause that stipulates a time frame for the filing of claims.

Termination Provision -The clause that outlines the methods and time frames under which the provider can terminate the contract.

Quality or Outcome Participation Requirement -A provision that the provider must participate with the carrier in collection of information and documentation efforts and/or with their quality programs.

Supersession Provision -A provision that a State regulation would supersede any contract clause.

Contract Update or Renegotiation Clause -Stipulates how and when the contract will be renegotiated and/or for what amount of increase.

Evergreen Clause -States that the contract is valid and in force in perpetuity or until a stated date or occurrence.

These clauses could be beneficial to the Certified Athletic Trainer and their practice but you should be aware of the pluses and minuses with each one.
Before signing a contract have your lawyer review it.

Contractual Provisions
Request copies of any documents incorporated by reference such as:

-provider policy and procedure manuals
-subscriber plan documents
-utilization and authorization procedures guidelines

It is good to have this language included in the contract:
Any document incorporated by reference in this agreement must be provided to provider prior to the execution of the agreement. No changes may be made to any such document without the prior written consent of the provider.

Questions to be asked and answered

Medical necessity- who determines medical necessity? Where are the criteria posted?

What is the contract term?
Does it include automatic renewal provisions or annual rate negotiations?

What are the termination provisions?
Notification of the covered person should be the responsibility of the plan.

What are the procedures to determine patient eligibility? Web based? Telephone system? Is a transaction number given?

Does the plan require other data than what is submitted on a clean CMS 1500 or 1450/UB 92?
Is coordination of benefits the plans responsibility or the providers?
How do you determine which plan is primary?

Include language that states the secondary insurance will accept the precertification/authorization compliance of the primary plan.

What are the provisions for dispute resolution?

What services can be billed to members? *Non-covered services, co pays, deductibles*

What is the time frame for submission of claims and payment of claims?

What fee schedule is being used?

Do not accept bundling of charges other than those shown under Medicare guidelines.

Sample contract 24 pages

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Section 3

Staking your claim

There are several claim forms available for use. We will concentrate on the most common, the Center for Medicare and Medicaid Services (CMS) forms. Most health care payers accept the CMS forms; form 1500 is a standard claim form for non-institutional providers and suppliers. CMS form 1450 or UB92 is the form used to bill for hospitalization and institutional services. Both of these forms are required when filing Medicare/Medicaid claims. They are available in paper or electronic (837) format.

The filing and re-filing of claims can be costly, frustrating and very time consuming, so completing the claim filing correctly the first time is essential. You should be aware that the majority of claim payers have prompt filing rules, rules that if violated may allow your claim to be rejected and denied. Know the payers time requirements, as well as any other requirements they may have, especially if they are not universal requirements. In some states there are also prompt payment laws that protect providers by mandating the turn around time for a "clean" claim. The Medicare time requirement for filing claims is 12 months. The Medicare time limit is liberal compared to many payers who prescribe a 30, 60 or 90 day time limits for filing a claim.

One of the most important things to do prior to treating a patient is to copy their "insurance" card and their driver's license and/or the driver's license and insurance card information of the responsible party. These two documents should provide you with most of the information you need to bill a carrier for services rendered. The insurance card also should have the phone number you will need to call for any pre-authorizations and instructions from the carrier. You should also have the patient or responsible party complete an information or data sheet for your records; one is included in this section as an example. Make sure that the policy number and members ID number are correct, include all letter designations and/or numeral sub sets, these have meaning to the payer. Most payers utilize a member's social security number as their member ID number. There are normally modifications to this number for each family member. Some plans do not use the Social Security number. Copy both the front and back of the insurance ID card, there is usually information on both sides. Claim adjusters are usually non-clinical personnel. Remember that in discussions or in any dealings you may have with them, you may have to explain your procedures in simplified or laypersons terms.
*Billing services are discussed on the next page.

The National Provider Identifier (NPI) has replaced the provider ID number issued by a carrier or payer beginning May 2007. Applying for an NPI does not replace any enrollment or credentialing processes with any health plan including Medicare.
To apply for an NPI visit https://NPPES.cms.hhs.gov

Claim forms should be filled out neatly and correctly, include all required information. Make certain that your diagnosis codes, ICD9, match your procedure codes, CPT4s. Submitting a diagnosis code for a sprained wrist and then submitting a procedure code for a sprained ankle will earn you a promptly rejected claim! **TOC**

How do you submit a claim?

There are steps to follow when submitting a claim correctly. If you have a billing department or a billing clerk, work with them. They are probably used to the idiosyncrasies of the various insurance programs. They also should have the latest CPT4, ICD9, DME and HCPCS code manuals. If not, you may have to supply them with the codes they will need. Additionally the clerk should be familiar with your State's practice law or Act. You do not want to commit fraud or overstep your legally allowable duties.

If you do not have a billing clerk on staff there are alternative methods for billing. Depending on anticipated volume, you can choose the method that is right for you. There are billing services, companies that will bill and fight with the carriers for you, naturally for a fee. Some billing services only receive re-numeration, a percentage of the claims collected or a commission amount, on claims submitted or paid. There are also billing systems and billing software available. You will need to evaluate all methods of billing and collection to determine which is the best for you and that best coincides with your style, practice and volume. You also need to think about and possibly develop a policy for bad debts.

Make certain you have the proper address to send the claims. The address for services or the local address and the claim center's address may be different. Most insurance/managed care organizations use centralized/regionalized claim centers. However the claim center for regular indemnity insurance coverage and for HMOs may be different. If your claim or bill is sent to the incorrect address, do not expect that some kind, caring person will re-route it for you. In all likelihood it will be trashed.

Paper claims forms have recently been updated to accommodate the NPI.

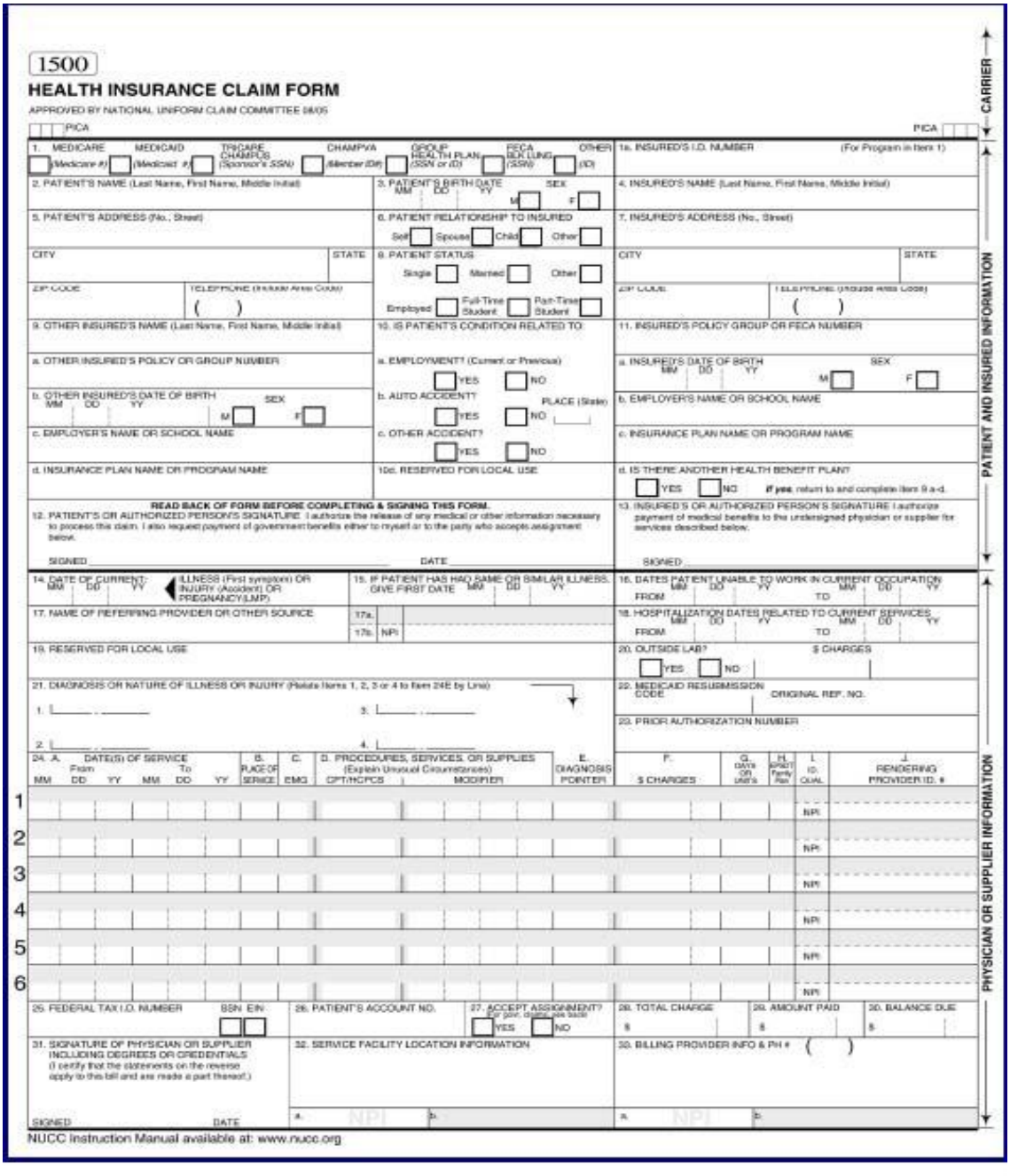
CMS 1500

CMS 1450/UB 92

Electronic Claims

NPI

Patient Insurance Sheet



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

The Form CMS-1500 (08-05) version will be effective January 1, 2007, but will not be mandated for use until April 2, 2007.

TOC

Athletic Training Revenue Code Effective in 2000

One of the key issues for athletic trainers working in the clinic and hospital settings is reimbursement. The simple fact is if athletic trainers work in these settings, they must be able to bill for services as an athletic trainer.

For those members employed in a hospital, third party billing has special challenges. Hospital revenue codes, found under Form Locator 42, are established by the Uniform Billing Committee of the American Hospital Association (AHA) These codes identify services and providers of the procedure codes (CPT code) used in patient care. For example, Category 42x. titled "Physical Therapy," is described as "Charges for therapeutic exercises, massage and utilization of effective properties of light, heat, cold, water, electricity and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic and other disabilities.'

When athletic trainers are able to bill in the hospital setting, payers often direct athletic trainers to use the 42x category with a subcategory modifier. However, many feel the use of the 42x category' by athletic trainers is misleading and possibly fraudulent.

In other cases, athletic trainers use the 94x series, titled "Other Therapeutic Services." defined as: "Charges for other therapeutic services not otherwise categorized." Subcategories include:
0-General Classification 3-Cardiac Rehabilitation 6-Complex Medical Equipment-Routine
1-Recreational Therapy 4-Drug Rehabilitation 7-Complex Medical Equipment-Ancillary
2-Education/Training 5-Alcohol Rehabilitation 9-Other Therapeutic Services

While the 94x series is appropriate in some cases, this series is not provider specific and use of the code often results in confusion by payers.

The only solution to these problems is to develop a code specifically for athletic training. After months of communicating with the American Hospital Association's Uniform Billing Committee, we were asked to complete an official application for a new code and present our argument to the Committee.

On November 8, 1999, we addressed the Uniform Billing Committee. After much discussion, the Committee determined that establishing a new category specifically for athletic training was not necessary. Instead, the Committee opted to expand the 94x category and create the 95x category, titled "Other Therapeutic Services, continued." Subcategory number one is titled "Athletic Training." Effective October 1, 2000, athletic trainers working in the hospital setting can bill under revenue code 951.

Remember that the payer is the ultimate decider in which revenue code to use on their claims. It is best to have in writing what their instructions are in regards to billing for athletic training services.

Section 4 Coding for Procedures and Diagnosis

In order to bill for medical services and supplies they must be coded. Coding is a complex subject that requires educating yourself or hiring a Certified Coder. Unless you hire a coder or billing agency you should purchase new coding books every year when they are updated.

Current Procedural Terminology (CPT) codes provide a uniform language that accurately describes medical, surgical and diagnostic services. CPT is a 5 digit numerical code. CPT codes may be used with 2 digit modifiers which further describe the service. Not all modifiers are listed in the CPT manual nor are they applicable to all codes. January 1st is the effective date for use of the updated CPT code set.

International Classification of Diseases 9th Revision, (ICD 9) (converting to ICD-10 in 2013) classifies morbidity and mortality information for statistical purposes, and for the indexing of hospital records by disease and operations, for data storage and retrieval. Physicians have been required by law to submit diagnosis codes for Medicare reimbursement since the passage of the Medicare Catastrophic Coverage Act of 1988. The ICD 9 code set includes codes that reflect health status, called V codes, because they begin with V and codes that classify external causes of injury and disease called E codes, they begin with the letter E. V codes and E codes may or may not be required depending on the health plan. The new years' ICD 9 codes are valid from October 1st through September 30th.

Healthcare Common Procedure Coding System (HCPCS) - Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established for submitting claims for these items. The development and use of level II of the HCPCS began in the 1980's. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

Place of Service is also recorded on a claim with a code. Place of Service Codes
Inclusion or exclusion of a procedure does not imply health insurance coverage.
Health plans use software to match procedure codes to diagnosis codes as a means of determining medical necessity. If you bill a shoulder x-ray with a diagnosis of foot pain, your claim will deny for not being medically necessary.

You must code to the highest level of specificity. Do not unbundle procedures, i.e. if one CPT accurately describes the procedure performed you may not use two separate CPTs in order to collect more reimbursement.

Codes used by Athletic Trainers

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Section 5 Reasons for Reduced Payments

I received ten cents out of the dollar I billed, what happened?

There are a number of reasons, some are even legitimate, why you may not receive the reimbursement that you billed for. We will review several of the common mistakes.

You have a contracted rate with the carrier; you contracted for one price then your billing clerk billed "fee for service" rates. The carrier will catch that in their system and only reimburse you for the negotiated rate.

You've billed the incorrect code(s) or you have made an error in your coding. Again the carrier will most likely catch the error and may adjudicate the claim based on what they believe is the correct information.

The carrier only paid you for partial services, they may have deemed some services inappropriate for the condition or code listed. Some of the service you provided may not be a covered benefit under the patient's plan, some of the service you provided was not pre-approved or authorized. The carrier removed those charges.

The carrier may be waiting to pay additional reimbursement after a primary carrier adjudicates the claim.

You did not collect the co-payment/co-insurance charge from the patient, you billed for the whole amount and the carrier deducted the patient's responsibility.

Section 6 Denials

They have paid $0, I've been rejected! Why?

If you are not paid or if the claim for payment is rejected, the carrier should send you a statement stating the reason. Some of the more common reasons are:

You are not a contracted entity; in the case of most HMOs for non-contracted providers there is no payment. You would have to seek reimbursement directly from the patient.

The carrier does not recognize that athletic trainer's services are reimbursable and/or they may not be reimbursable under the carrier's program or the patient's plan.

Services were not pre-approved or pre-authorized and they were required to be.

You used the incorrect codes or you did not supply a code or the codes you used were

outdated. Make sure the billing staff is kept up to date with the latest coding manuals.

You used the wrong forms; CMS 1500 was used for an inpatient stay when a CMS 1450 should have been used.

You did not submit your bill within the required time frame. You were delayed and did not meet the timely filing provision.

Pattern billing, billing of a single code creating a pattern effect. The computers are programmed to catch this and it may reject your claim or forward it for investigation.

Duplicate billing. You already billed for this service and the claim was adjudicated.

Billing for services/procedures not performed, more common than you may think.

Medical Record documentation not complete or lack of documentation; missing information.

You treated an HMO or other managed care member and you did not or they did not obtain a referral for treatment.

The most common error is missing or un-readable information on a claim.

There are numerous errors that can be made, luckily most of the errors only delay the claim or cause a re-submittal of the claim, costly and time consuming but fixable.

The explanation of benefits (EOB) or remittance advice (RA) you receive from the health plan will give the reason for denial. The industry is moving toward a unified code system, but some small companies may still be using a unique system.

The standard reason code set is found at this site:
http://www.wpc-edi.com/codes/claimadjustment

The remark codes give a more detailed description of the denial, these codes usually start with a letter.
http://www.wpc-edi.com/codes/remittanceadvice

Sample EOB

Medicare Claims Processing Manual
Chapter 22 - Remittance Advice

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Section 7 Appealing Denials

If you believe the carrier/claim payer is in error, they rejected your claim and/or they paid incorrectly and/or they have not paid or rejected the claim and it has been months since it was submitted. What can you do?

First, make sure your facts are correct and that you have all of your documentation in order. Review the reason codes on your EOB. You can send a letter to the carrier but the most common result from your letter would be a form letter response in return.

Health Plans have an appeals process that usually involves a series of steps from one level to another. The first step is usually a phone call to the claims department, then a formal appeal which is always in writing. There are usually one or more appeal levels which could lead to a legal review. Always keep copies of all correspondence related to an appeal, record the name of the persons you spoke with and the dates.

Call the claims area and speak to a Supervisor or above. The claim technician, the one that answers the call, may be unable to assist you beyond providing you with information you may already have. The Supervisors, Managers, Directors are normally the only people with the power to override an already adjudicated decision. So speak to them! If you do not understand the reasoning for his or her decision, the technician may be able to aid you, but once you need to have a decision reversed or corrected you will probably need to speak to someone in Management. The telephone review is going to be the easiest and fastest way to gain reimbursement.

If the claim you submitted was “clean”, the term clean indicating it was filled out properly with no errors, you may be able to rely on the state insurance board to assist you. In a number of states laws have been enacted that require insurance programs/managed care companies to pay clean claims promptly.

If you are right, do not take NO for an answer, move up the chain of management, asking to speak to the next person’s supervisor and then the next etc. Before using this technique, make double sure you are correct! Remain polite, do not burn any bridges, but be insistent.

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Section 8

Where do you go for help when all else fails? There are a number of places:

Your local State Representative for the Council on Revenue.

The Regional/District Representative on the Council on Reimbursement.

The NATA National Manager of Markets and Revenue.

Your state insurance board or managed care office may assist. Normally these are the same offices but possibly different divisions.

The Internet, the web has numerous claim information sites.

Your billing department, your contracting department, your patient.

Fighting denials article

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Section 9

Glossary- click link

Know the native tongue; make sure you and the carrier are speaking the same language.

Section 10

Success Stories –Scroll Down to next page.

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Getting reimbursed for services we (ATC's) provide. What Are We Waiting For??

You may be thinking this is another article on third party reimbursement and it's importance to our survival in the marketplace, right? Wrong! What I would like to take a moment to review is, what we should be doing **now** for reimbursement, while we skeptically tread the waters of 3rd party fees for services.

The question above is "What are we waiting for?". The answer to that question is as complex and puzzling as 3rd party reimbursement itself. Some of us are waiting for others to get the ball rolling, others are waiting for legislative actions or decisions, and still others are waiting for the NATA to provide us with the framework to do this. (Which those of you who have attended the NATA-COR course on reimbursement know is already in place)

What I'd like you to consider, is this. We provide a service, which we, as Certified athletic trainers feel is of vital importance to the physically active individual. To both the healthy individual preparing for or trying to improve physical performance, and the injured individual trying to return to a normal level of function for whatever activity it is that they wish to return to. So let's provide these services and collect a fee for what we do. It's that simple, and already being done in many ways at many different levels.

For those of you who work at a professional, college/university or school setting, you are paid a salary to provide the services of a Certified athletic trainer on a daily basis. This may be through a contract or salaried position, but you collect a fee for what you do. In other settings, Clinical/Industrial/Corporate many of you collect a fee to provide services in various settings, from those listed above to health and wellness centers, rehabilitation centers, physician offices, corporate fitness programs, Health and Safety coordinators for industries, etc.

As we have all heard time and time again, we are our own best advocate and must continuously market and promote ourselves on a daily basis. The more people we impress with our services when we come into contact with them, the stronger we become as an individual professional and as a National Organization.

There are many obstacles depending on where you work, who you work with, what your state regulates you can or can not do, but they are all barriers to be overcome in building a stronger profession. If our founding members had stopped or given up each time they were faced with a barrier to overcome, you would not be reading this article today, and we would not be **Certified** athletic trainers. The continued growth and success of our profession relies on all of us to be our own best advocate, but to work together towards common goals..

The opportunities are there and bountiful in many areas of the country to go out and not only provide our services, but earn a living doing it and promote our profession along the way. Just a few examples of employment opportunities are, provision and development of community education programs for local and state recreational facilities, YMCA's, Health clubs. Coordinator of health and safety programs for a local company or corporate industry, consulting for local youth and amateur athletic associations on injury prevention and management, as well as providing coaches education programs.

> Jim,
> Thank you again for all your help with Cigna
> Insurance. Your correspondence
> with Brian expediated the process tremendously. It
> appears now that Cigna
has decided to take care of all the claims that were
previously denied and
> will be changing their policy with regard to payment
> for Athletic Trainer
> services. I will send an email to Brian thanking
> him for his involvement.
> We also wanted to let you know how much Carle
> Hospital, Carle Therapy
> Services, and most of all Carle Sports Medicine and
> our Athletic Trainer's
> appreciates your efforts. Thank you for all you do
> for the Athletic
> Trainer's in the State of Illinois.
>
> Mark Rieger

=====

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President
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PO Box 578025
Chicago, IL 60657
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TOC

From: Alan Kroll [alan.kroll@attbi]

Sent: Sunday, February 02, 2003 9:08 PM

To: paulc@nata.org

Subject: reimburement

paul, i am an atc in nyc. i have been treating dancers and preforming artists with dance companies and broadway shows. i have been reimbursed each time i bill for both workmans comensation and actors equity insurance. the companies that have paid so far are chubb, aig, liberty mutual and union labor life. i have been reimbursed on par with a physical therapy payment schedule. if you need any specific info please feel free to email me or call at 646 263 5323.

alan

Subject: BC/BS Reimburses TN- ATC's

Keith-

I was at the Tennessee Athletic Trainers' Association meeting this past weekend. Nick Pappas, President of TATS, stated that effective Jan. 1, 03, Blue Cross & Blue Shield will reimburse for Athletic Training Services. The physician must write "atheltic training" on the prescription. ATC's must stay within their scope of practice.

Just thought you would be interested in this information.

David

David Jones, MS, ATC/L
Director of Sports Medicine
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ntgomery, AL 36106
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Pricing across the country is consistent with out-patient PT or OT
services--most ATCs are using the same fee schedule. Phys. Ext. reimbursement is getting around 60-70% per $ billed, with very, very few denials (1-2% of claims). Outpatient rehab services vary across the country, with many major carriers reimbursing well for AT services. Indiana
seems to be getting really good reimbursement when ATCs are billing under
their own provider codes. I don't have any specific #s to share there--just
anecdotal info others are willing to share. Good luck, and thanks for the
note. Let me know if I can help further.

Sue

Sue Finkam, MS, ATC/L, CEA
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air, NATA CIC Committee

Closing

A closing thought;
You may be entering a new environment with new ideas, obstacles, interactions, and rejections. You will need someone to post payments, handle transactions, send bills and collect bad debts. You or a staff person will need to confront reticent third party payers and challenge them. You will need to maintain records and documentation unlike you have done previously. You will have to learn coding CPT, ICD, HCPCS, V and E codes a whole new language for some. These and numerous other challenges will present themselves, is it all worth it? Of course it is!

To truly move athletic training into the new century and continue building our program into a recognized allied health profession the pain has to be endured before the gains can be secured! Thank you.

References

http://www.cms.gov

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