

# Billing 101: What You Need to Know

Reimbursement from third party payors is a complex issue. Successful accomplishment of third party reimbursement for services provided by an athletic trainer (AT) takes a concerted effort from individual ATs, employers (particularly senior leadership support), referral sources, medical coders, AT State Associations, and the National Athletic Trainers' Association (NATA). Detailed in this document are issues that need to be addressed, questions that need to be answered, and resources to utilize. This is not an exhaustive list and is intended only as a starting point. These questions need to be answered as a beginning step. This work will direct the AT to resources and to the next steps in the reimbursement process.

Question: Are you licensed, certified or registered as an AT in the state where you are practicing or want to practice? Start here if not!

Question: Do you have your National Provider Identifier (NPI)?

- For more information and how to apply, visit [NATA's NPI Resource Page](#).

Question: Do you know and understand your state AT Practice Act? If not, contact your state regulatory board or AT association.

- Review your state practice act on [NATA's State Regulatory Boards](#) and watch [NATA's Scope of Practice Webinar](#).
- How is an AT defined in your state practice act?
- Who can ATs treat?
- In what settings can ATs work?
- Which medical professionals can manage/supervise/refer to you?
- Are there restrictions in billing or receiving reimbursement?

Question: Are you aware of what third party billing/reimbursement activities are occurring in your state? If not:

- Visit your state association website.
- Contact your state association president.
- Contact your state Committee on Practice Advancement (COPA) chair.

Question: Do you understand that referral/treatment orders must be for athletic training, sports medicine, or physical medicine? *ATs cannot treat under an order for physical therapy (PT) or occupational therapy (OT).*

Question: Are you covered under a professional liability insurance policy for the services you are providing as an AT?

- Is your employer providing insurance coverage?
- Are you certain that your facility's blanket coverage covers services provided by an AT, and other professional activities? Investigate, ask questions, and confirm.
- Do you need your own coverage as well? This is your own personal decision.
  - [NATA's Preferred Providers](#)
  - *These are not the only providers for professional liability insurance for ATs. Do your due diligence and shop for the best coverage and pricing.*

Question: What type of practice are you in?

- This dictates which billing system and forms will be utilized.
  - Private Practice.
  - Health System or Hospital Based.
  - College/University.

Question: Do you know and understand what billing forms, billing system, and American Medical Association (AMA) Current Procedural Terminology (CPT) codes to use?

- What forms will you or should you be using?
  - [HCFA - CMS 1500 Form](#)
  - [UB04](#)
- What AMA CPT billing codes should be used for services provided?
  - See "[Codes Used by Athletic Trainers](#)"
  - AMA Current Procedural Terminology Book - CPT 2016 Professional Edition
    - Call to order - 1.800.621.8335
    - [www.amastore.com](http://www.amastore.com) - product number EP888814 or EP054114
- What CPT codes can ATs use?
  - *"Throughout the CPT code set the use of terms such as 'physician,' 'qualified health care professional,' or 'individual' is not intended to indicate that other entities may not report the service. In selected instances, specific instructions may define a service as limited to professionals or limited to other entities (e.g., hospital or home health agency)." CPT Code Book - page xii*
    - This statement means that CPT codes are not "profession specific." Any qualified health care professional can utilize any code as long as the code description fits the procedure or service the professional is providing.
  - Documentation must be appropriate to support the CPT code being utilized.
  - If not properly documented, code will be denied.

### **Billing Fact: ATs, PTs, and OTs**

Question: Whose NPI will you bill under?

- Will you bill directly under your AT NPI as a professional performing a service within his/her scope of practice and who independently reports that professional service? Or,
- Will you bill as a clinical staff member, under another medical professional's NPI?
  - You may be permitted to so if you are working directly under the physician, or other qualified health care professional, and it is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.

## Billing Fact: "Incident To"

Generally, ATs should not use "Incident to" language. The term "Incident to" was created by the Centers for Medicare and Medicaid Services (CMS), the Agency that administers Medicare and Medicaid. CMS does not recognize ATs as Medicare providers. However, commercial insurers tend to follow Medicare "incident to" guidelines. Please read the insurer's policy manual and verify whether the insurer utilizes "incident to terminology," and if so, in what circumstances it is permitted. If "incident to" language is used, coders and billers may not approve the claim.

*All Medicare providers of professional services – To qualify as "incident to," services must be part of your patient's normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment. You do not have to be physically present in the patient's treatment room while these services are provided, but you must provide direct supervision, that is, you must be present in the office suite to render assistance, if necessary. The patient record should document the essential requirements for incident to service. – [CMS MLN Matters](#) (April 9, 2013).*

Question: What pricing strategy will be employed for your services?

- How are you setting your fees?
  - Many practice consultants set practice fees at a percentage of the Medicare Physician Fee Schedule (MPFS), which is public knowledge.
    - Many payors set reimbursement rates at a percentage of the MPFS.
    - To look up MPFS in your geographic region, visit the [CMS Medicare Fee for Service Payment](#).
- Are you going to be an all insurance-billed business, or will cash payment be a part?
  - It is recommended that your practice or business have one master fee schedule for all patients.
    - It is not a good policy to have different fee schedules for different classes of patients. This can cause issues in "most favored nation" contracts with third party payors.
  - It does not mean every class of patient pays the same fee; designated class(es) of patients can be given a standard reduction off fees.
    - Must be a written policy (i.e., all patients paying cash will receive a 40% reduction of charges)

Question: Do insurers in your state recognize and accept ATs as qualified health care professionals?

- Check with your state COPA Chair to see if they have information on insurers in the state that recognize ATs and/or regularly reimburse for services provided by an AT.
- If your state AT Practice Act does not restrict ATs from billing or receiving reimbursement for services rendered, then it is legal to bill when following your state practice act, practicing within your scope of practice, and following appropriate coding guidelines.
  - Employer should be informed and approve of AT billing for services.
  - Must ensure proper referral for AT services, ICD-10 and CPT coding, and appropriate billing form utilization.
  - Insurer will respond with Explanation of Benefits (EOB) that either pays claim or denies payment. The EOB will explain why payment was denied.
  - If a denial is due to lack of recognition of an AT as a qualified health care provider, there is a process to officially appeal the insurer's decision.
    - This is an opportunity to educate the insurer on AT licensure, education, skill, etc. The AT must demonstrate his or her worth and value.

Question: What insurers credential or contract with ATs or other allied health professionals?

- Some insurers do not credential or contract with any allied health professional – they only contract with physicians.
- Each insurer has a business process that the AT must learn and address as part of doing business.

Question: What is the process for obtaining a contract or getting credentialed with a payor?

- What is the difference between being contracted with and being credentialed?
  - **Contract** – Contact between insurer and care provider for services rendered.
    - Provides the basic information, including state regulatory requirements, to become an approved provider of a specific insurance company.
  - **Credentialed** – Credentialing is the process of reviewing, verifying, and periodically re-verifying a health care professional's credentials in accordance with the payor's credentialing criteria.
    - Essentially, the insurance company is verifying to members that the contracted professional has met the requirements of licensure, expertise, professional history and liability.
    - Council for Affordable Quality Healthcare (CAQH) is utilized by majority of payors and health systems to collect data for credentialing. For more information: <https://proview.caqh.org/pr> or [providerhelp@proview.caqh.org](mailto:providerhelp@proview.caqh.org)
  - A practitioner who is currently credentialed with a payor and is changing job sites needs to notify the payor.

Visit [nata.org](https://www.nata.org) for more information on billing and revenue.

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