Reimbursement and Role Delineation: What is it and Who is Qualified?

Jeff G. Konin, MEd, ATC, MPT
Instructor, Athletic Trainer
Delaware Tech

Julie Max, MEd, ATC
Athletic Training Program Director
California State University–Fullerton

In the rapidly changing world of health care, the word reimbursement seems ever so prevalent in the vocabularies of more and more individuals. Regardless of whether one is speaking with a physician, an athletic therapist, an insurance provider, or physically active individuals themselves, the term reimbursement is commonly heard.

In fact it may be one of the few buzzwords that actually connects these various individuals together as each focuses on desired outcomes related to health care.

But what exactly is reimbursement, and how does role delineation of the athletic therapist affect future outcomes? Is it simply a numerical value of currency one is entitled to in exchange for the delivery of services or products? Or does reimbursement also include an element of bartering?

If the answer to either or both questions is yes, wouldn’t it seem that each individual, regardless of profession, is reasonably capable of collecting dues for services rendered or products supplied? One would think so. Why is it, then, that athletic therapists, particularly athletic trainers, must struggle to receive fair and equitable compensation for the delivery of quality health care?

To answer this question, we need to examine the history of reimbursement as it relates to health care providers in the U.S.

Mechanisms of Reimbursement

When you go to the grocery store to buy a gallon of milk, you have a number of choices. You can buy 1%, 2%, skim, whole, or even chocolate milk. But regardless of the milk you choose, you must pay for it at the time of purchase. In fact the principle of paying for goods at the time of purchase is standard practice and ranges from retail to dining.

Yet it seems this principle has not only been dismantled but even abused when it concerns the delivery of health care services. Can it be that helping individuals achieve optimal health is less important than material goods? Most of us would answer no. So why is it that we have allowed others to dictate the timing of when our services should be paid for?

DeCarlo (1997) has identified four primary sources through which health care services are typically reimbursed: the federal government, state and local governments, health insurance agencies (usually via businesses), and personal household income and philanthropy. With such diversity, one would expect a fair reimbursement for services. However, each of these primary sources has evolved to a point at which it is facing difficulties.

Medicare and Medicaid, both government funded, may well be headed toward extinction. In order for these two programs to continue paying for the services provided to those who qualify, adjustments will have to be made for the rapidly growing older population and increased life expectancy in general.

Originally these programs were not designed to provide for medical services over an extended period of time. The necessary changes could require an increase in taxes and/or cuts in other government funded programs, neither of which would be popular.

Whether through family business or large corporation, many employees have opted for packaged policies that are offered by insurance companies. While these policies are often attractive and sometimes the only reasonable option for an employee, it is truly the insurance company itself that sets all the standards.

Employees are given choices, but only those choices indicated
by the insurance company. Typically, employees pay a yearly deductible and work with a pro-rated and predetermined percentage of payment for services rendered. For example, one might pay a $500 yearly deductible. Once the deductible is reached, the insurance company may pay 80% of the fees and leave the individual to pay the remaining 20%.

The remaining form of reimbursement involves a direct relationship between provider and recipient. In years past this was a popular method.

However, the cost of health care services has made this type of reimbursement all but impossible. Many believe that only the wealthy can afford to take this approach. The average consumer is not likely to pay for health care services out-of-pocket these days.

Steps to Receiving Reimbursement

In the traditional athletic training room, athletic trainers are paid a salary to provide all the necessary evaluation procedures and treatments required to keep their athletes healthy. This is managed care at its best. It's called capitation and involves rendering health care to a specific population for a fixed amount of money.

However, beginning in the late 1970s, other health care professionals began providing health care for physically active patients utilizing their typical fee-for-service approach. Consequently, athletic trainers employed in sports medicine clinics and in corporate and industrial settings found themselves functioning in the fee-for-service environment. This development requires athletic trainers to be knowledgeable about the world of reimbursement.

If one were to pick a key word for successful reimbursement, it might be "documentation." The paper trail of information needed to receive reimbursement for services rendered includes diagnostic coding, procedural coding, subject information, evaluative findings, daily treatment notes, progress reports, discharge notes, insurance claim forms and, possibly most important, outcomes results.

Chondromalacia patella, medial epicondylitis, and plantar fasciitis are terms the athletic trainer knows well. But how many athletic trainers know what "ICD" means? It is the abbreviation for International Classification of Diseases, an umbrella document of diagnostic codes that is accepted as the language by most, if not all, private insurance agencies (Practice Management Information Corp., 1997). To be reimbursed for a service, it is imperative for one to properly classify an injury.

Another abbreviation often echoed in the reimbursement world is "CPT." It stands for Current Procedural Terminology, a system that classifies the type of procedure rendered (American Medical Association, 1997).

These procedures are labeled using 5-digit codes that are standardized nationally. They were developed by the American Medical Association in consultation with an allied health advisory board. Successful reimbursement must include appropriate paperwork that clearly identifies the proper CPTs.

Qualifications Needed for Reimbursement

To this point we could agree that the NATA Role Delineation study revised in 1995 and the academic preparatory domains needed for NATA certification qualifies the athletic trainer to render services to the physically active. We could also agree that the services an athletic trainer renders to the physically active are deserving of reimbursement and that, given proper documentation, there should be no reason why this cannot be accomplished.

Why, then, do athletic trainers have such difficulty when it comes to billing for services? Are athletic trainers qualified to be reimbursed according to the guidelines set forth by the American Medical Association? The answer is yes!

From a CPT coding perspective, the codes are generally for use by any qualified physician. However, certain codes may be used by non-physicians as well. Many of these are listed in the "Physical Medicine" section of the codes, where the term "provider" is a general term used to define the individual providing