Divine Savior Healthcare Rehabilitation Services

2817 New Pinery Rd
The Wellness Center
Suite 1
Portage, WI 53901
608-745-6290

Steve Allison, LAT
Matt Bekkedal, M.Ed., LAT
James Shlimovitz, LAT
Jason Cerkoney, LAT
Andrew Acker, LAT
Lauren Kluz, LAT

The Reimbursement Movement
Learning Objectives

- The history of licensure in WI.
- Implementation strategies for clinical reimbursement.
- Identified reimbursement pitfalls and strategies to overcome them.
- Learning about the new AMA evaluation codes.
- Clinical documentation guidelines.
- Billing and coding.
- Developing clinical competencies.
- Getting started with clinical reimbursement.

Conflicts of Interest

- Independent Contractor: Consultant with OrthoVise, LLC.
  - *NATA and WATA Third Party Reimbursement Project, Implementation Lead.*

The Reimbursement Movement

- NATA Third Party Reimbursement Initiative
- Wisconsin State Business Development Team
- WATA
- IATA
- OATA

About Me… ☺

About me continued….

- Athletic Trainer in Wisconsin over 26 years.
- Graduate of UW-Stevens Point.
- Attended Kansas University.
- A runner by background - fostered my interest in Athletic Training.
- Spent ALL of my career in the rehabilitation clinical setting.
- Enjoy working with:
  - Pelvic/SI dysfunction.
  - Low back pain/radiculopathy (DiMaggio Techniques).
  - Gait/foot analysis and casting for orthotics.
  - S/P shoulder rehabilitation (RTC, Bankhart, Labral).
  - Assisted in the implemtation of a new “Spine Clinic” program at DSH to address chronic/recurrent low back/cervical pain patients.
- ***Proud that many of our MD’s, administration and staff at DSH choose AT for their rehabilitation needs.***

Divine Savior Healthcare
Rehabilitation Services

- **Divine Savior Healthcare - WELLNESS CENTER 2016**
  - **Rehabilitation Services:**
    - **Physical therapy, Occupational therapy, Athletic Training.**
      - » **Outpatient: 21 PT's, 3 PTA's, 5 OT's, 2 COTA's, 6 LAT's.**
  - **Occ. Health and Podiatry Services.**
  - **Orthopedics.**
  - **Speech/Language Pathology/Audiology.**
  - **LaVita "Medically Integrated" Fitness Center.**

  - **Portage, WI (Population: 10,183)**

Athletic Training Services at DSH

- ***Current AT functions/responsibilities:***

  - **Rehabilitation Clinic**.
    - Evaluation, establish POC, provide treatment and D/C of rehabilitation patients.
    - Bill third party insurance for AT services.
    - Practice/function autonomously in the rehabilitation setting.

  - **Clinical care coordination with DSH Orthopedics/ED through outreach programming.**

  - **Outreach services to 6 affiliate schools.**
    - Provide after school and event medical coverage.

  - **Industrial Services**
    - Onsite services (sports medicine model of care).
    - Work conditioning (billing worker's comp).
    - FCE's.
    - Ergonomic assessments (office ergonomic assessments).

  - **Wellness Programming** - Employee and community.

  - **Summer programming**.
    - Speed/agility, Caring for Sports Injuries, ACL Symposium, The Athletic Arm Symposium ...

The Reimbursement Movement

- March 2001 (2000): Wisconsin AT Licensure.
  - Practice Act: Patient defined as an “Athlete”
- 10/2001: National Uniform Billing Committee of the American Hospital Association granted Licensed Athletic Trainers a UB 04 number of **0951**.
  - This Code enables Licensed Athletic Trainers to bill within the hospital setting.
- 1/2002: The CPT Committee of the American Medical Association granted the use of procedure codes 97005 and 97006. (New Evaluation Codes for 2017)
  - 2010 Amendments to Practice Act – “Physically Active”

The Reimbursement Movement

The Reimbursement Movement
“Relationships”

- Meet with rehabilitation director/manager
  - Improve access to rehabilitation.
  - Generate revenue.

- Meet with rehabilitation professional staff. Propose AT’s as autonomous providers in the rehabilitation setting:

  - ***Building relationships – mutual respect and trust.***

- Discussions with front desk staff
  - Outline an AT evaluation and treatment procedural *flowsheet:*
    - Current insurance companies reimbursing for AT services.
    - Is the patient physically active?
    - No neuro cases.

- Business Office
  - Add **97169**, **97170**, **97171**, and **97172** to charge master, align charges consistent with PT/OT evaluations/re-evaluations.

The Reimbursement Movement
“Human Resources”

- Human Resources: Update ***job description*** related to Athletic Trainers:
  - **Performs evaluations.**
  - **Establishes POC.**
  - **Selects appropriate treatment interventions.**
  - **Documents to accepted standards.**
  - **Conducts discharge planning.**

  - *Mirror the PT job description.*

The Reimbursement Movement
“Human Resources”

Wisconsin Society of Healthcare Human Resources Administration (WSHHRA)

Job 304: Athletic Trainer

Assists staff Physical Therapists *in treating patients and provides on-site athletic training services for area athletic teams. This includes conducting seminars and developing relationships with sports and medical organizations on behalf of the facility.*

Athletic Trainer: Proposed Jan. 2017

Healthcare professionals who render service or treatment, under the direction of or in collaboration with a physician, in accordance with their education and the Wisconsin State Practice Act. As a part of the healthcare team, services provided by ATs include ***injury and illness prevention, wellness promotion and education, emergent care, clinical evaluation and assessment, therapeutic intervention and rehabilitation of injuries and medical conditions.***

WSHHRA Athletic Trainer: Current proposed changes

- *Prevent, recognize and evaluate* ***athletic injuries****. Manage and administer the initial treatment of* ***athletic injuries****, and rehabilitate and physically recondition athletic injuries. May provide onsite athletic training services for area athletic teams. This includes conducting seminars and developing relationships with sports and medical organization on behalf of the facility. Must be a Certified Athletic Trainer and be licensed to practice in the State of Wisconsin****.***

The Reimbursement Movement
“Electronic Medical Records” (EMR)

- *EMR Headers:* ***Athletic Training Services***
  - *Initial Evaluation.*
  - *Plan of Care.*
  - *Daily Notes.*
  - *Discharge Summary.*

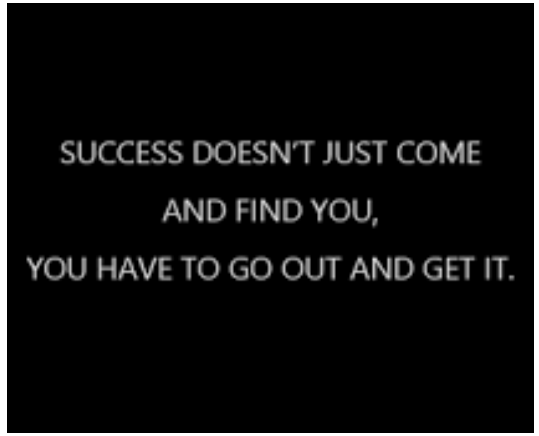
  - ***OrthoVise, LLC working diligently with EMR’s to implement Athletic Training language that is built into the EMR.***
    - ***Epic***

The Reimbursement Movement
“Providers”

- AT added to scripts for rehabilitation:

  ___PT ___OT ___AT

- Built this into our EMR.
- Meet with primary referring providers; discuss support/request referrals.
  - AT Rehabilitation Services.
  - ***Rehab triage patient to appropriate discipline***.



The Reimbursement Movement
"*Implementation of AT Rehabilitation Services*"

- ***Athletic Training Reimbursement in the Outpatient Rehabilitation Clinic Setting.***
  - ***"A Checklist and Roadmap for Success."***

Current Athletic Training Services at DSH
Outpatient Rehabilitation Services

- *2017: Currently have 5 AT's functioning autonomously;*
  - *Performing evaluation and treatment of patients in the clinical rehabilitation setting, billing third party for their services.*
- *All DSH scripts come from our physician's with (PT or OT or AT).*
- *Many/Most out of network scripts now come with PT or AT ordered, if not, will send clarification order for signature.*
- *AT's function under the referral of an MD, DO, DC, PA, Podiatrist, APNP's.*
- *Currently we have had success with 5-6 insurance companies (WC included) who recognize and reimburse for AT rehabilitation services at DSH on a consistent basis.*

The Reimbursement Movement
WATA Third Party Reimbursement Pilot Study

Divine Savior Healthcare

- Pilot study: 7/1/2015 - 6/30/2016
  - 423 AT patients
  - Initial evaluations using CPT Code 97005
    - Established treatment plan and billed appropriate therapy CPT codes

Revenue Gross Charges:
$1,301,844.73

Billed in clinic as autonomous providers

- Billing same evaluation rate $$ as other rehabilitation disciplines.

Reimbursement % from payors has been consistent with PT and OT.

The Reimbursement Movement
WATA Third Party Reimbursement Pilot Study

- Outcome data collected - Pilot study
  7/1/15-6/30/16

- ***S/P Shoulder -Surgical: RTC repairs, SLAP/Labral repairs, Bankart repairs, SAD's…etc.***

  Goal: QuickDASH patients scoring <29 at discharge.
  Perceived level of function for return to work.

  -

- N = 34
- Average Visits to Discharge: 15 (Payors 16-20 visits)
- QuickDASH score at evaluation: 45
- QuickDASH score at discharge: 10

The Reimbursement Movement
"Identified Pitfalls along the Journey"…

- **State Practice Act**
  - **Does your State Practice Act allow for it?**
    - **What are you qualified to do? Licensed vs. Registered professionals.**
  - **Use of CPT Codes: "Qualified Medical Professional."**
  - **Only CPT Codes specific to a discipline are the eval codes.**

- **Licensure**
  - **Payors not recognizing ATC, needed to demonstrate "Licensure".**
  - **Payment for services based on "LAT" credentials.**

- **Denial of Services: Insurance companies not recognizing or reimbursing rehabilitation services by an AT.**
  - **Dealing with Reimbursement Denials.**
  - **NATA Website – "Billing and Reimbursement."**
  - **www.nata.org/practice-patient-care/revenue-reimbursement/billing-reimbursement**

The Reimbursement Movement
"Identified Pitfalls along the Journey"…

- **Insurance companies self-interpreting the role of the AT and/or defining a limited scope though internal policy.**
  - **Educating payors of our Practice Act.**
  - **Reimburse for AT services that other "like" disciplines are being reimbursed within the rehab setting.**
  - **Educate schedulers of payors that reimburse for AT services.**

- **Held to same productivity standard as PT/OT.**
  - **Limited third party payor's recognizing AT rehabilitation services.**
  - **Discuss up front with manager that schedules may be initially light, or remain light based on limited payors.**

- **AT staff covering schools/events in the afternoon. Difficulty with patients/scheduling during this time.**
  - **Split AT positions Clinic/Schools can offer challenges; "burn-out".**
  - **Peak clinic volumes early am's/after 3pm (issue for AT schedules)**
  - **AT's need to be initially flexible with clinic scheduling.**

- **Summer: Staffing in clinic.**
  - **Empower AT's to hold summer clinics/symposiums etc.**

The Reimbursement Movement
"Identified Pitfalls along the Journey"…

- **Limited number of insurances who recognize for AT rehabilitation services.**
  - **Keeping AT schedules full.**
  - **Productivity limitations.**
    - **Counting game/event stats.**

- **Ensuring the AT is competent with clinical evaluation and treatment.**
  - ***What competencies do you have in place?***
  - ***Will discuss competencies further!!***

- **Clinical documentation and goal writing.**
  - ***Good review for all disciplines.***
  - ***Will discuss in more detail!***

- ***Understanding coding and billing??***

The Reimbursement Movement
"Identified Pitfalls along the Journey"…

- **Other disciplines concerned AT's get all of the "fun" patients.**
  - **Ensure the athlete population is spread evenly with other disciplines.**
- **Trends of higher modality use by AT's as compared to other disciplines.**
  - **Athletic Training Room Mentality?**
  - **Selling point to get the "athlete" to rehabilitation.**
- **2015 Clinic outcome data show AT's hanging onto patients longer.**
  - **Increased WC patient loads?**
  - **Increased athletes case loads?**
  - **AT schedules not as busy compared to other disciplines?**
    - **Are they hanging on to patients longer?**

The Reimbursement Movement
DSH Outcome Data 2016

Upper Extremity

- 2016 Clinical outcome data at DSH very favorable for AT.
  - MCID (minimal clinically important difference)
    - Higher value demonstrates greater improvement at discharge.
    - **All disciplines ~5 point move** utilizing QuickDASH

  - Upper Extremity (Non-surgical)
    - PT visits to discharge 8.94
    - **AT visits to discharge 7.67**
    - OT visits to discharge 7.81

Lower Extremity

- 2016 Clinical outcome data at DSH very favorable for AT.
  - MCID (minimal clinically important difference)
  - **9 point move** using the LEFS outcome (PT/AT)

  - Lower Extremity (Non-surgical)
    - **PT/AT identical in visits to discharge 7.7/7.8**

The Reimbursement Movement
AMA New Evaluation Codes for 2017

- American Medical Association is bring 3 levels of evaluations
  - Low Complexity
  - Moderate Complexity
  - High Complexity

- Evaluation & Re-evaluation Codes for PT, OT and AT professions
  - **AT 97169, 97170, 97171 and 97172**

  - PT 97161, 97162, 97163 and 97164
  - OT 97165, 97166, 97167 and 97168

    - 97005/97006 No longer utilized

The Reimbursement Movement
Opportunities: Documentation/Evaluation Pitfalls

- Clinical Evaluation: Level of Complexity.
  - Perform too quickly?
  - Incomplete
    - Not thorough, not assessing contributing factors, comorbidities…
    - Need to tell a story.
    - Show justification and need of your skilled care.
    - What is limiting them from normal function.
    - Don’t make it all about sports.
    - “Physically Active”

The Reimbursement Movement
AMA Evaluation Codes 2017

History **Personal factors or comorbidities that impact POC**	**Physical Exam** **Of Body System(s) using standardized tests from body structures and functions, activity limitations and/or participation restrictions**	**Clinical Presentation**	**Clinical Decision Making – using standardized patient assessment instrument and/or measurable assessment of functional outcome**	**CPT Assignment**
None	1-2 elements	Stable and/or uncomplicated characteristics	Low Complexity	**PT- 97161** **OT- 97165** **AT- 97169**
1-2 personal factors	3 elements	Evolving presentation with changing characteristics	Medium Complexity	**PT- 97162** **OT- 97166** **AT- 97170**
3 or more personal factors	4 or more elements	Unstable presentation and unpredictable characteristics	High Complexity	**PT- 97163** **OT- 97167** **AT- 97171**

The Reimbursement Movement Evaluation Assignment Grid

History and Physical Activity Profile

that affect physical activity

Personal Factors

- Age
- Gender
- Coping Styles
- Social Background
- Education
- Profession
- Fear Avoidance
- Readiness for Change
- Exercise Habits
- Cognition
- Communication Ability, including need for translators
- Anxiety
- Psychological Problems
- Support System
- Home Environment
- Secondary Gains
- Motivation
- Past & Current Experience
- Overall Behavior Pattern
- Character

Co-Morbidities

Past/Current History

- Medical Hx
- Surgical Hx
- Weight/BMI
- Diabetes
- Arthritis
- CHF
- COPD
- Etc.

Function

Prior/Current Level of Function– how current level has decreased compared to status prior to onset

Injury/Illness/ Exacerbation

- Mechanism

Time since onset

Physical Exam

Of affected body area(s) and other symptomatic or related systems using standardized tests from body structures and functions, physical activity and/or participation deficiencies

Body Structure

- Body Regions: Head, Neck, Back, Trunk, UE, LE, organs
- Body Systems/Impairments:
  - Musculoskeletal (gross symmetry, ROM, strength, height, weight)
  - Nervous system – gross coordinated movement (balance, gait, locomotion, transfers, transitions) and motor function (motor control, motor learning)
  - Cardiovascular (heart rate, respiratory rate, blood pressure, edema)
  - Integumentary (pliability/texture, scar formation, skin color, skin integrity)
- Body Structures – Structural or anatomical parts of body, such as organs, limbs and their components classified according to body systems

Body Functions

Functional Limitations

- Mobility – walking, standing, transfers, stairs, etc.
- Self-Care – bathing, dressing, feeding, etc.
- Sleeping
- Driving
- Work

Activity Limitations

Difficulty carrying out a task or action (requires modification of the activity to perform it)

- Assist of another person (cueing, hands on assist, etc.)
- Use of an adaptive device/tool

Participation (in Life Situations) Restrictions

Problems an individual may have in involvement in life situations in current environment

- Domestic Life – shopping, meal preparation, housework, assisting others
- Interpersonal Interactions & Relationships
- Major Life Areas – school, informal education, economic transactions

Community, Social & Civic Life – recreation & leisure, religion & spirituality, community life

COGNITIVE

- Ability to attend, perceive, think, understand, problem solve, mentally sequence, learn, and remember, resulting in the ability to organize occupational performance in a timely & safe manner.

Observed when person 1) attends to & selects, interacts with, & uses task tools & materials; 2) carries out individual actions & steps, and 3) modifies performance when problems are encountered.

Clinical Decision Making – using standardized patient assessment instrument and/or measurable assessment of functional outcome

Stable and/or Uncomplicated Condition

Pain worse at onset and improving, expected to continue to improve (e.g. muscle strain – initially a lot of pain and tightness, has improved some since onset)

Evolving or Changing Condition

Symptoms progressed since onset, not getting better & could say they are getting worse (e.g. back injury – at onset, pain just in back but now starting to go down leg)

Unstable and Unpredictable Condition

Symptoms not predictable; doesn't follow specific pattern, fluctuating symptoms, may be unsafe (e.g. orthostatic hypotension & patient passes out)

CPT Assignment

Low Complexity = Eval Level 2 Old Codes

- No personal factors or co-morbidities that impact plan of care
- 1-2 elements from Body Structure, Body Function, Activity Limitations, and/or Participation Limitations
- Stable & uncomplicated condition
- Low clinical decision-making complexity
- Typically, 15-30 minutes are spent face-to-face with the patient and or family

Moderate Complexity = Eval Level 3 Old Codes

- 1-2 personal factors or co-morbidities that impact plan of care
- 3 or more elements from Body Structure, Body Function, Activity Limitations, and/or Participation Limitations
- Evolving or changing condition
- Moderate clinical decision-making complexity
- Typically, 31-45 minutes are spent face-to-face with the patient and or family

High Complexity = Eval Level 4 Old codes

- 3 or more personal factors or co-morbidities that impact plan of care
- 4 or more elements from Body Structure, Body Function, Activity Limitations, and/or Participation Limitations
- Unstable & unpredictable condition
- High clinical decision-making complexity
- Typically, 46-60 minutes are spent face-to-face with the patient and or family

Re-Evaluation

- An assessment of changes in patient functional or medical status with revised plan of care
- An update to the initial profile to reflect changes in condition or environment that affect future interventions and/or goals
- Includes additional diagnosis

A revised plan of care. A formal re-evaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. An examination including review of history and Typically, 20 minutes are spent face-to-face with the patient and or family

The Reimbursement Movement
Documentation: Evaluation & Treatment Summary

- **Who** (patient).
- **What** happened (be brief).
- **Where** (work or non work related).
- **Why** (objective findings point to ___).
- **How** (will you fix it with your skill).
- **Estimate a reasonable time frame. How Long?**
- Assure prior level of function is clearly shown and what the patient needs to get back to for functional ability.
- This assessment is all the further a reviewer should have to go.

The Reimbursement Movement
"What the Payer (Insurance) Needs to Know"

- Prescribed by a medical provider.
- Provided by a ***"licensed"*** provider.
  - AMA CPT Codes: ***"qualified healthcare professional"***
  - ***ATC vs. LAT***
- Signed (by the referring provider) treatment plan.
- Don't make it about sports….Think function!!
- **Reasonably expected to promptly restore or minimize degeneration of functional ability.**
  - Prior Level of Function?
  - Diagnosis / Prognosis / Prior therapy / Prior progress as evidenced by the medical documentation.
  - Expected gains in a reasonable period of time.
    - How long? This goes back to diagnosis, prognosis, etc.

The Reimbursement Movement
"What the Doctor Needs/Wants to Know"

- **Should you "diagnosis"?- no**
  - Judge in a careful, thoughtful way.
  - Final decision.
  - Qualifications indicate your ability to diagnosis.
- **Should you "assess"?- yes**
  - Judgement, "***thoughts or opinion".***
  - Condition Ongoing/Changing/Evolving.
  - Competency and skills indicate your ability to assess.
- **A summary of your findings- clear, concise.**
- **What are you going to do about it-**
  - You've been commissioned by the doctor to help.
  - What service will help the condition?

The Reimbursement Movement
Re-Evaluation 97172

- Must be an existing plan of care in place.
- Revising this plan of care.
- Requires examination with review of history AND use of standardized tests and measures.
- Note- if you are progressing current plan of care, usually not a re-eval, but if you are adding something new (new body part, condition), then a re-eval is warranted.

The Reimbursement Movement
Daily Note- True Evidence of Your Skill

- **Subjective Reporting**

- **Pre Treatment Assessment**
  - **Utilize what they tell you.**
  - **Utilize what you see/observe.**
  - **Adjust treatment to address needs.**

- **Treatment (objective)**
  - **Utilize clinical tool box <u>but don't overuse.</u>**
  - **Ultrasound, iontophoresis, e-stim and exercise all in 1 treatment? What worked?**
  - **Evidence Based Practice is here!**
  - **Be cautious of only strengthening (why can't they be on a home program?).**

- **Post Treatment Assessment and Plan**
  - **Did your treatment impact pre-treatment assessment?**
  - **How do you know it helped/ worked?**
  - **Measureable responses to treatment.**
  - **What should occur at the next treatment.**

The Reimbursement Movement Assessment & Goal Setting

- Your clinical judgement, ideas and opinion based on your objective assessment of the condition.
- Problem lists ➔ Create Goals.
  - Show the deficit and then state what is normal or expected.
  - Decreased Range of Motion in Right Shoulder.
    - Right Shoulder Active Flexion 80 deg (160 deg on left).
    - Right Shoulder Active Abduction 70 deg (130 deg on left).

The Reimbursement Movement
Goals

- **Objective**-
  - Should be measurable by you and anyone else that might be involved.
- **Include Function.**
  - Why do you need __ range of motion to do ___?
  - Why do you need __ strength to do __?
- **Time Specific.**
  - Short Term (progress in 4 wks).
    - Surgical cases in particular or if requesting more visits beyond initial.
  - Long Term (end of therapy).

The Reimbursement Movement
Final Tips

- **Document at Point of Care When A**
  - Efficient.
  - Best notes when information is fresh.
- **“Paint the picture” for the provider and insurance payer.**
  - Clear & Concise.
- **Capture your skill-**
  - Why does the patient need you?
  - Why not a home program?
- **Know when to change gears.**
  - If what your doing isn’t working, try a different approach.

The Reimbursement Movement
ICD-10 Procedure Codes

- ICD-10 is the 10th revision of the **International Statistical Classification of Diseases and Related Health Problems (ICD**), a medical classification list by the World Health Organization (WHO).
- It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.
- Over 69,000 codes that can be further sub-classified into over 16,000 codes.
  - Combination of diagnosis and symptoms with more specificity.
  - ICD-9 was not as specific, hence ICD-10 evolved.
  - **Provider gives us the medical diagnosis code**.
  - **Therapy will add treatment codes:**
    - **Examples: Right knee patient .**
      - **M25.561 Right knee pain.**
      - **M53.1 Weakness.**
      - **M25.661 Right knee stiffness.**

The Reimbursement Movement
"Assessment & Treatment Codes" (CPT)

- **CPT = Current Procedural Terminology**
  - Maintained by the American Medical Association.
  - Designed to maintain a consistent set of medical services and procedures used to treat patients.
  - CPT are the services administered to assess or treat the patient's condition.
- CPT codes are used by health insurance companies to pay claims.
- Timed codes (15 minutes = 1 Unit).
- Non-Timed codes (evaluations).

- ***97000 Series are Physical Medicine/Rehab codes and can be used by any "qualified healthcare professional".***

The Reimbursement Movement
"Billing and Coding"

- **Level I HCPCS Codes = CPT codes**

  Medicare Rules indicate the 8 minute rule to coding.

  - 1 unit ≥ 8 minutes to < 23 minutes
  - 2 units ≥ 23 minutes to < 38 minutes
  - 3 units ≥ 38 minutes to < 53 minutes
  - 4 units ≥ 53 minutes to < 68 minutes
  - 5 units ≥ 68 minutes to < 83 minutes
  - 6 units ≥ 83 minutes to < 98 minutes
  - 7 units ≥ 98 minutes to < 113 minutes
  - 8 units ≥ 113 minutes to < 128 minutes

- **Level II HCPCS Codes are specific to non-physician services like medical equipment.**
  - A letter always starts a Level II HCPCS Code.
    - L-codes are common to braces (orthotics/prosthetics).

The Reimbursement Movement
Looking ahead……?

- Insurance companies requiring a therapy modifier code for 2017.
  - Modifiers are added to billing to delineate discipline for insurance company.

- Therapy Code Modifier Key:
  - GN: Services provided outpatient SLP.
  - GO: Services provided outpatient OT.
  - GP: Services provided outpatient PT.

***Currently **NO** therapy modifier for AT outpatient services as CMS doesn't formally recognize AT's as a provider.*

The Reimbursement Movement
“Billing and Coding”

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 N
0951	ATHLETIC TRAINING	97110	050216	3	38850	
0951	ATHLETIC TRAINING	G0283	050216	1	12950	
0951	ATHLETIC TRAINING	97110	050916	3	38850	
0951	ATHLETIC TRAINING	97110	051116	3	38850	
0951	ATHLETIC TRAINING	97110	051716	2	25900	
0951	ATHLETIC TRAINING	97110	052416	2	25900	
0951	ATHLETIC TRAINING	97110	053116	2	25900	

The Reimbursement Movement
“Identified Pitfalls”….

- **What is the comfort level of the AT in the clinic setting?**
  - **What is the level of training within the educational setting from which the AT graduated?**
    - **Inconsistency among educational programs?**
    - **Clinical rehabilitation tracts.**
  - **Clinical evaluation skills? (not an athletic training room eval)**
    - **Clinical Evaluation Competencies.**
  - **Athletic training room documentation vs. clinical documentation?**
    - **Documenting for Insurance, Physician's…needs to be more thorough.**
  - **Use/familiarity of EMR*?***
  - ***This poses a question for potential employers:***
    “How does a healthcare entity know that an AT is competent in a clinical rehabilitation setting?”

The Reimbursement Movement
Educational Programs: Clinical Internships

- Educational Programs Transition to Master's.
  - Focus on clinical rehabilitation.
  - Training to address differential diagnosis/comorbidities.
  - Clinical rotation – Internship.

The Reimbursement Movement
“Clinical Competencies”

- Evaluations
  - Observation of other disciplines.
  - Clinical evaluation observed (non-patient).
  - Mock Evaluation – Critiqued by supervisor/clinical mentor.
  - Live evaluation with observation by supervisor/clinical mentor.

- Documentation
  - Review/Learn EMR system.
  - Consider scribing for another clinician.
  - Assign clinical mentor to review documentation.
  - Attend or hold an “Essentials of Documentation” presentation.

- Modalities
  - Clinician lead modalities in-service.
  - Cover indications/contraindications, best evidence, etc.

- CEU Considerations
  - Identify clinical skills/deficits.
  - Attend CEU course work specific to clinical needs.

The Reimbursement Movement
“Clinical Considerations” – Clinical Comfort Level

- **Expect that an AT can effectively evaluate and progress rehabilitation plan of care:**
  - **Joint conditions/injuries.**
    - **Shoulders, elbows, hips, knees, ankles.**
  - **Musculotendinous Injuries.**
  - **Work Injuries – Work conditioning – FCE’s.**
    - **Ergonomic Assessments and Recommendations.**
  - **S/P Surgical**
    - **Shoulder – RTC, Labral, Bankhart etc.**
    - **Hip – THA’s, Hip arthroscopy, Femoroacetabular Impingement (FAI).**
    - **Knee – TKA’s, ACL, Meniscectomy/Meniscal repair, Osteoarticular Transfer System (O.A.T.S.), Microfracture.**
    - **Foot/ankle – Ankle/Foot reconstructions, O.R.I.F’s, Bunionectomies, Achilles repair.**
    - **Lower leg – Compartment syndrome.**
    - **Low back – micro discectomy.**
  - **Hip/SI dysfunction– Important for AT’s to seek additional training in this area – common injury amongst athletic population.**
  - **Low back**
    - **Axial low back pain, DDD/DJD, lumbar instabilities.**
    - **Radiating/referred pain?? – with additional training/CEU’s.**
  - **Cervical?**
    - **If training specific to cervical issues.**

The Reimbursement Movement
“Implementation of Athletic Training Services”

Getting Started…

- Worker’s Compensation
  - Evaluation/Treatment of WC patients.
    - Traditional therapy.
  - Work Conditioning
    - A transition from therapy to prepare for RTW.
  - FCE’s
- Self-Insured business.
- Industrial Services – Job agility testing.

The Reimbursement Movement
NATA and WATA Third Party Reimbursement

- ***Implementation Lead with OrthoVise, LLC***

- ***Work diligently with the NATA Third Party Reimbursement initiative to:***
  - ***Increase number of insurance companies recognizing and reimbursing for AT services***
  - ***Continue to assist healthcare systems with implementation of AT rehabilitation services.***
  - ***Available to answer questions AT's have regarding reimbursement.***
  - ***Presentations (GLATA, MATA, TPR conference)***
  - ***Invite you to contact me with questions!!***

- ***The Reimbursement "Movement" – Continued Support***

The Reimbursement Movement
NATA and WATA Third Party Reimbursement

Positive Trends….

- ***Working at National Level – State Practice Acts.***
- ***More Payors recognizing AT rehabilitation services.***
- ***More Healthcare Systems allowing AT's to evaluate and treat in rehabilitation setting.***
- ***PT directors/Healthcare systems are inquiring on implementation process of AT's into an autonomous clinical role.***
  - ***Seeing the value of a clinical AT.***
- ***Increased productivity opportunity for AT's in clinic.***
- ***Improves patient access to rehabilitation.***
- ***Bundled payment?***
- ***Increased patient satisfaction.***
- ***Increased job opportunity for AT's.***
- ***Drive increased salary considerations for AT's.***
- ***Work-Life balance – generating revenue (40 hr/wk)***

The Reimbursement Movement Implementation and Advocacy

- Steve Allison
  - Independent Contractor: Consultant with OrthoVise, LLC
  - *NATA and WATA Third Party Reimbursement Project, Implementation Lead.*
  - *sallisontc@gmail.com*

OrthoVise, LLC

Joe Greene

joegreene@orthovise.com

Athletic Training Services at DSH

Steve Allison, LAT
Rehabilitation Supervisor

Divine Savior Healthcare
Rehabilitation Services
The Wellness Center
2815 New Pinery Rd
Suite 1
Portage, WI 53901
608-745-5961
sallison@dshealthcare.com

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