The Study of Third Party Reimbursement and its Effect on the Responsibilities and Salaries of Certified Athletic Training in the Clinical Setting

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THE STUDY OF THIRD PARTY REIMBURSEMENT AND ITS EFFECT ON THE RESPONSIBILITIES AND SALARIES OF CERTIFIED ATHLETIC TRAINING IN THE CLINICAL SETTING

A RESEARCH PROJECT PRESENTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR GRADUATION IN SPORTS ADMINISTRATION, LYNN UNIVERSITY

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BY LES FULLER
APRIL 13, 1999

APPROVED BY
Dr. Richard A. Young
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CHAPTER 1

Introduction

Statement of the Research Problem

Insurance companies are not recognizing athletic training services as a reimbursable entity.

What effect will third party reimbursement have on the responsibilities and salaries of certified athletic trainers in the clinical setting?

The Problem and Its Setting

The Statement of the Problem

This research proposes to identify the changes that may take place within sports medicine clinics in regards to certified athletic trainers’ salaries and duties.

The Sub-problem

The sub-problem is to determine if supervisors/administrators/managers will acknowledge athletic training as a viable option to create new revenue.

The Hypothesis

The first hypothesis is that additional responsibilities will be created within the clinical setting due to the potential for reimbursement.

The second hypothesis is that salaries will increase because of the athletic trainer's abilities to contribute to revenue producing services because they are recognized by the state as a regulated health care profession.

The third hypothesis is that demand for athletic training services will increase within the clinic setting resulting in an increase in athletic trainers being hired.

Definitions

Certified Athletic Trainer (ATCs)—An ATC is someone who is certified by the National Athletic Trainers Association Board of Certification and is trained in the prevention, physical evaluation, emergency care, physical reconditioning relating to injuries and illnesses occurred through sports induced trauma. These injuries may occur during the preparation for participation in sports competition or during a physical training program either of which an educational institution, amateur or professional athletic group sponsors, or other recognized organizations.

National Athletic Trainers Association (NATA)—As the number of athletes participating in organized sports grew during the mid-1900, a great demand for
qualified persons to care for the medical needs of the athletes arose. Athletic trainers were needed to assume the day-to-day responsibility for the medical care of the athlete. As the demand on those in athletic training increased, they felt a need to organize on a national level. The organization was developed to discuss issues of mutual concern such as ensuring the development of proper educational programs in the field of athletic training, establishing standards of care for athletic trainers, and exchanging ideas on injury management and prevention. The National Athletic Trainers Association was organized to oversee the developments in the athletic training field.

*Outcomes Studies*--The outcomes studies predicts resource consumption, identifies and adjusts patients expectations, helps patients and providers chose among treatment options, identifies targets for quality improvement and reduces costs.

*Health Care Finance Administration (HCFA)*--a federal organization that stipulates Medicare providers.

*Third Party Reimbursement*--Reimbursement has been historically defined as a numerical value of currency that one is entitled to in exchange for the delivery of services. Someone other than the client receiving rehabilitation services usually pays for the services. These payment sources include independent health plans, private insurance companies, and government health care programs. Collectively, these payers are known as the third party payers (Konin 23).

*Sports Medicine Clinic*--Sports medicine is a term that has many connotations, depending on whom or what group is using it. Sports medicine is broadly designated as multi-disciplinary, including the physiological, biomechanical, psychological, and pathological phenomena associated with exercise and sports. The sports medicine clinic application of the work of these disciplines is performed to improve and maintain an individuals functional capacity for physical labor, exercise, and sports.

*License*--The process of becoming a professionally licensed health care provider for a person’s respective state. The requirements for becoming a licensed athletic trainer in the state of Iowa is as follows:

1. An applicant for athletic training licensure must posses the following qualifications:

   A. Graduation from an accredited college or university and compliance with the minimum athletic training curriculum established by the department in consultation with the board.

   B. Successful completion of an examination prepared or selected by the department in consultation with the board.
2. An out-of-state applicant for an athletic trainer license must fulfill the requirements of subsection 1, paragraph "a" and "b", and submit proof of active engagement as an athletic trainer in the other state.

3. Application and renewal procedures, fees, and reciprocal agreements shall be provided in accordance with the Iowa Department of Health (Hunt 11).
CHAPTER 2

Literature Review

A. Historical Overview

Reimbursement for athletic training services has moved to the forefront of the profession; it has been called the trend of tomorrow, the issue of importance, the key hurdle for professional growth. But the topic can be daunting: insurance companies, managed care, paperwork, state legislation, competing professionally, politics, educational parameters, more paperwork—each play a role in the complex structure of third party reimbursement.

Professional changes have taken place in the past years that include new work opportunities outside the traditional setting of the college. Jobs are opening in clinical settings, whether privately owned, hospital-based or in corporate facilities. Because of these changes, ATCs are realizing the importance of receiving compensation for the services they provide (Cambell 34). The current philosophy is the more third party payers there are reimbursing for athletic training services, the more jobs and better security that will result. Educational reform has already pushed to the forefront in efforts to standardize education and prepare for the future of third party reimbursement. Accreditation standards builds professional recognition needed to compete in the allied health care industry (Konin 25).

Reimbursement advisory groups have been formed to research issues designed for devising strategies for success. Three goals have been outlined to help in the gaining of reimbursement. One goal that is underway is a three-year outcome study that has just been completed this year. More than 3,500 patient episodes were recorded; all received more than 90% of their care from certified athletic trainers (Albolm 33). The results unfailingly show a high level of effectiveness and patient satisfaction with athletic training services. The second step is to develop a model approach to payers (insurance companies and managed care providers). The final step is to educate certified athletic trainers and related parties about the issues surrounding third party reimbursement (Godek 12).

The following is the clinical applications of the outcome studies and the results. Using a scale of 0 = lowest rating and 4 = highest rating, important findings are:

1. 3,450 participating patients (total number of patient episodes) rated their satisfaction with certified athletic trainers at 3.88.

2. Patients rated their satisfaction with treatments provided by the certified athletic trainer at 3.87.

3. Patients rated their overall pre-treatment status at 2.43 following a treatment program by a certified athletic trainer, patients rated their overall status at 3.55.
4. Patient ratings of their overall status prior to treatment by certified athletic trainers were 2.27 in sports medicine clinics, 2.58 in high schools, 2.63 in colleges and universities and 2.49 in industrial settings. These values increased to 3.38 in sports medicine clinics, 3.75 in high schools, 3.73 in colleges and universities and 3.60 in industrial settings following the completion of treatment of certified athletic trainers.

5. Patients rated their pre-treatment ability to participate in sports or recreational activities at 1.76. Upon discharge from a program of care provided by the certified athletic trainer, patients rated their ability to participate in sports or recreational activities at 3.27.

6. Patients rated their pre-treatment ability to participate in work-related activities at 2.20. Following a treatment program by a certified athletic trainer, the rating increased to 3.47.

7. Prior to initiating a program of care provided by a certified athletic trainer following injury or surgery, patients rated their status for movement, strength and sensory perceptions at 2.20, 2.20 and 2.14 respectively. Upon discharge, patients rated their values at 3.55, 3.47 and 3.45, respectively.

8. 262 patients who underwent reconstructive surgery rated their overall status at the initiation of treatment by the certified athletic trainer at 2.07. At discharge from the treatment program, the patients rated their overall status at 3.49.

9. Patients with grade III, or severe, sprains rated their overall status at 2.04 at the initiation of treatment by a certified athletic trainer. The rating improved to a value of 3.47 at discharge from the treatment program.

10. The average number of treatments provided during the treatment program ranged from a high of 18.77 for colleges and universities to a low of 11.44 in industrial settings. The average for sports medicine clinics and high schools were 11.96 and 12.77, respectively.

11. The total number of treatment is a positive factor in determining overall outcomes.

12. As the number of days increased between the date of injury or surgery and the beginning of treatments by the certified athletic trainer, the patient’s rating of their overall outcomes decreased (Godek 13).

B. Communication and Third Party Payers

A significant part of successful reimbursement revolves around the communication between the provider and the insurer (Schunk 106). Most of the individuals the provider will deal with from the third party payers organizations will not have any formalized training, inservice or education to assist them with
understanding what athletic training is. Nor will they know what constitutes the need for athletic training services, how effective athletic trainers are, what diagnosis athletic trainers treat, what treatment approaches are utilized successfully, the extent of an athletic trainer's education, how athletic trainers are regulated, or the results of outcomes related to athletic training services (Iowa 55).

C. Outcomes Data and Reimbursement

The previous section has explained the athletic training outcome data and how it relates to the importance of reimbursement and the future of athletic training as a profession. When specifically targeting athletic training outcome data to third party payers as a means for supporting either original claims or appeals, there are four major types of outcome data that can be beneficial: clinical, functional, satisfaction, and cost (Wade 64). Clinical outcomes focus on the achievement of goals that are reflective of physical changes occurring as a result of intervention. In other words, clinical outcomes demonstrate ratings of such parameters as strength, range of motion, swelling and pain. Functional outcomes are slightly different in that they do not necessarily consider what the normative data is compared to the measurements recorded clinically. Instead, functional outcomes answer the question of whether or not an individual can now accomplish a task that they have set forth to do in their goals which were altered as a result of the injury or illness. An example of a functional outcome would be whether or not an athlete can throw a baseball with the same mechanics and effectiveness prior to the injury. It is quite possible that this athlete may have good strength, normal range of motion, no swelling and no pain, which equates to a positive clinical outcome. Nonetheless, the very same athlete may not be able to throw the baseball effectively, thus having a poor functional outcome. A satisfaction outcome is typically found in the form of a survey, which is based upon feedback of the patients who have received the services provided by the athletic trainer (Webster 63). While this may be an easy way to collect data, it is extremely subjective in nature and may be influenced not only by the clinical and functional outcomes, but also by the personality of the athletic trainer and the other personnel associated within the facility that renders the treatment. Cost outcomes are important in this day and age as they demonstrate financial responsibility on the part of the provider. A provider who can achieve successful clinical, functional or satisfaction outcomes while at the same time doing so at a lower cost to the patient will win the praise of the third party payer (Third 15).

D. Health Care Finance Administration and Federal Regulations

The issue of reimbursement requires that athletic trainers communicate with the HCFA. Most of the individuals treated by certified athletic trainers are not covered by Medicare or Medicaid; however, many private insurance companies base their standards on Medicare and Medicaid standards when determining what services to pay and which service providers to reimburse (Le Postollec 46). Once a certified athletic trainer or athletic training entity is recognized as an official
Medicare or Medicaid provider, other insurance companies may be willing to follow suit.

Because the identity of the certified athletic trainer is not commonly known in the current healthcare environment, it often takes considerable justification and documentation for payers to consider reimbursing athletic trainers for the care, which they provide (Abeln 45). Many times claims for reimbursement are denied simply because of this lack of recognition. Inclusion of certified athletic trainers in the HCFA Medicare statutes, which clearly define providers, creates immediate recognition. This recognition provides payers with the information that they need to identify certified athletic trainers as reimbursable entities and is essential to furthering the reimbursement efforts of athletic trainers (Albohm 33).

E. State Regulations

To be a recognized Medicare/Medicaid provider, athletic trainers must apply on a state-by-state basis. NATA legal counsel is pursuing the appropriateness of contacting the insurance commissioners in each state and the Association of State Commissioners to determine individual state insurance regulations. Many states have insurance regulations that address who can and cannot be a provider. The first step is to determine whether your state law restricts billing for services. The question is not whether you can bill, but whether insurance companies will pay. When third-party payers evaluate a claim, one of the first things checked is whether the provider is recognized by the state as a regulated health care professional and if the services performed fall within the provider's legislated scope of practice (Le Postollec 47). In most states if it is legal for you to perform physical therapy, rehabilitation or treatment in your state, then a policy that includes this provision is obligated to pay.

The Medicare and Medicaid federal government regulations that define provider categories do not specifically name certified athletic trainers. To fit within the physical therapy category, however, guidelines state that one must be a recognized physical therapist, or be otherwise qualified. The otherwise qualified provision opens the door for athletic trainers to qualify as Medicare and Medicaid providers (Hunt 10).

A state agency’s willingness to allow athletic trainers to qualify under its state regulations will be highly influenced by the content and quality of the presentation made to them and the skills of the presenters. The complexity of these issues reinforces the need for well-planned and carefully executed communication with providers and various influential organizations (Gray 12).

It is extremely important to refrain from organizing any individual arrangements with payers, at any level, until more facts are known. This will insure that unnecessary “roadblocks” are not created making the process more difficult and creating unfavorable legislation (Fowler 110). The NATA Governmental Affairs Committee and Reimbursement Advisory Group are working together closely.
with NATA legal counsel to provide the membership with accurate information and appropriate guidance.
CHAPTER 3

Methodology

A questionnaire was mailed to supervisors/administrators/managers to explore the future services provided by hospital and outpatient rehabilitation departments within the state of Iowa. The survey was sent to 95 rehabilitation service and sports medicine clinics. Addresses were obtained from the American Physical Therapy and Physical Therapy Assistant Association directory. Each program director received a mailing containing a cover letter describing the purpose of the study, a survey instrument, and a prepaid self-addressed return envelope. A sample of the survey is provided in table 1.

The survey consisted of 9 questions designed to explore current responsibilities of athletic trainers, annual salaries, satisfaction levels of employers, and potential changes if third party reimbursement is passed into legislation.

Table 1

Dear Supervisor/Administrator/Manager:

The following is a brief survey designed to explore the future services provided by hospital and outpatient rehabilitation departments within the state of Iowa. All Physical therapy and sports medicine clinic supervisors/administrators/managers were selected to determine what effect third party reimbursement would have on the responsibilities and salaries of certified athletic trainers in the clinical setting. Although you are in no way obligated to complete this survey, I hope you will take a few moments to assist in the data collection process.

Included is a self-addressed stamped envelope. Please place completed survey in this envelope and mail it at your earliest convenience. This survey will help me complete the final phase of a Master's program in Sports Administration. Your help with this collection process is greatly appreciated. Thank you!

Please answer all questions that apply as accurately and honestly as possible.

1. Do you employ certified athletic trainers (ATCs) at your clinic? YES NO

2. If you answered YES to question #1, how many ATCs do you employ?

3. If you answered NO to question #1, what is the best explanation for this?
   - Qualifications, education, etc.
   - Type of patients seen
   - Lack of reimbursement for athletic training services
   - Lack of funds for new or non-traditional personnel
   - Little or no high school or college coverage possibilities

4. How would you rate your satisfaction of the athletic trainer abilities within your clinic?
   - Very Satisfied
   - Somewhat satisfied
   - Neutral
   - Dissatisfied
   - Very dissatisfied

5. If third party reimbursement was available for athletic training services would your practice change to include certified athletic trainers as part of your staff or comprise a larger portion of your staff? (PLEASE MARK ONLY ONE YES OR NO QUESTION)
   - YES, I would hire an ATC
   - NO, I would not hire an ATC
   - YES, I would hire more ATCs
   - NO, I would not hire more ATCs

6. If you answered YES to question #5, what responsibilities would they perform?
   (PLEASE MARK ALL THAT APPLY)
   - Patient Therapy
   - Marketing
   - High School Athletic Trainer
   - Administration
   - Camps
   - Evaluations
   - Strength Coach
   - Sport Evaluations Only
7. If you currently employ ATCs, what is the salary range that they fall under? (PLEASE MARK USING A NUMBER THAT CORRESPONDS TO THE NUMBER OF ATHLETIC TRAINERS IN THAT SALARY RANGE)

<table>
<thead>
<tr>
<th>Salary Range</th>
<th>Number of ATCs</th>
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<tbody>
<tr>
<td>Under $15,000</td>
<td></td>
</tr>
<tr>
<td>$15,000-20,000</td>
<td></td>
</tr>
<tr>
<td>$20,001-25,000</td>
<td></td>
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<tr>
<td>$25,001-30,000</td>
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<tr>
<td>$50,000 Or more</td>
<td></td>
</tr>
</tbody>
</table>

8. Would you increase the salaries for ATCs because of their abilities to contribute to revenue producing services and for being recognized by the state and insurance carriers as regulated health care professionals?  YES  NO

9. If you answered yes to #8, what would be the increase for a year's salary?

<table>
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<th>Year's Salary</th>
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<tr>
<td>$3,500</td>
<td>$4,000</td>
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<tr>
<td>$6,500</td>
<td>$7,000</td>
</tr>
<tr>
<td>$9,500</td>
<td>$10,000</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>
CHAPTER 4

Results

Of the 94 surveys mailed, 59 were returned (62.8%). There was one unusable questionnaire, due to the therapist being an instructor. The adjusted return rate was 58 (61.7%). The total number of responding supervisors that employed ATCs was 27 (46.5%) and 32 did not (54.2%). Each clinic employed a varying number of ATCs. The greatest number of ATCs employed at one clinic was 9 and the 17 different clinics employed one ATC. The 27 clinics who employed trainers averaged 2.15 ATC per clinic (mean average). The median and mode numbers was one. The 27 clinics employed a total of 58 certified athletic trainers.

The clinics that did not employ ATCs were asked to give reasons to best explain their position: 6 (18.2%) stated that qualifications and education standards of ATCs were lacking, 18 (54.5%) responded that the clientele was not suited for an ATC, 13 (39.4%) for lack of reimbursement for ATC Services, 7 (21.2%) was because of lack of funds for new or non-traditional personnel, 4 (12.1%) for little or no high school or college coverage possibilities, and 1 (3%) did not respond (More than one answer could be chosen).

Clinics employing ATCs were asked to rate their employees abilities: 17 (62.3%) responded that they were very satisfied with their abilities, 6 (22.2%) were somewhat satisfied, 4 (14.8%) were neutral, 0 (0%) were dissatisfied or very dissatisfied.

To explore the future of athletic training, supervisors were asked if reimbursement would change their hiring practices. They were asked that if reimbursement were available would their practices change to include ATCs as a part of their staff or comprise a larger portion of their staff. The supervisors who did not currently employ ATCs stated that they would hire an ATC if the services were reimbursable at a rate of 22 (68.7%); while 11 (34.3%) said they would not hire an ATC. The supervisors who currently employ ATCs responded with 12 (44.4%) saying they would hire more ATCs and 15 (55.5%) said they would not hire more ATCs.

The Supervisors/Administrators/Managers who responded by saying they would hire an ATC or more ATCs were asked to mark what responsibilities they would perform. Combined, 36 total Supervisors/Administrators/Managers indicated they would hire one or more ATCs if reimbursement were available for athletic training services. The 36 total responded by 20 (55.5%) working patient therapy, 29 (80.5%) high school coverage, 11 (30.5%) sport camps, 13 (36.1%) strength coach, 14 (38.8%) marketing, 2 (5.5%) administrator duties, 0 (0%) evaluators, and 17 (14.2%) sport evaluations.
A question was posed to find out the current salaries of the 58 certified athletic trainers in this survey. After the data was accumulated, 36 athletic trainer’s salaries were reported. The results show one ATC earning under $15,000 per year, five ATCs earning between $15,001-20,000 a year, 7 earning between $20,000-25,000, 17 earning between $25,001-30,000, five earning between $30,001-35,000, and one earning between $40,000-50,000.

Being able to contribute to the revenue of a rehabilitation clinic is key for the survival of the certified athletic trainers and the NATA. Twenty-three (39.6%) of supervisors/administrators/managers stated they would increase the salaries of ATCs if reimbursement was available, 26 (44.8%) would not increase salaries, and 9 (15.5%) did not answer.

The last question asked what type of salary increase would be deserving of an ATC if their services were reimbursable. A total of 14 of the 23 health care professionals who responded yes to question number eight gave their opinions. The salary increases and the number of supervisors/administrators/managers suggesting an increase are as follows: $500-1,000 (1), $1,000 (1), $1,000-$1,500 (2), $1,500 (2), $2,000 (2), $2,500 (2), $3,000 (1), $3,500 (1), $2,000-5,000 (2).
CHAPTER 5

Discussion and Conclusion

The problem of determining the future of the certified athletic trainer has not been an easy task. Reimbursement has been a solution sought after as a means to change the credibility of the profession by gaining the respect of the HCFA, Medicare/Medicaid, state regulatory committees, and other health care professionals. Although reimbursement has passed as law in several states, more effort to standardize education must take precedence to ensure that all certified athletic trainers are equipped to provide the best possible care to patients.

Much of the future of reimbursement will depend on how health care shapes itself in the next couple of years. The fight for dollars amongst health care providers and third party payers will not become much easier as we enter a new era of health care delivery. Regardless, the providers and the consumers must stand up for what they believe is correct and demand quality services. When a provider has an ample opportunity to deliver quality care to the point of patient satisfaction and good functional outcomes, perhaps all parties will then come to an agreement on a rational system for reimbursement. A system that runs efficiently and effectively will no doubt benefit all that utilize the services of claims filing.
CHAPTER 6

References


CHAPTER 7

Bibliography


