Athletic Training Coding Overview

This overview is intended to address coding considerations that are specific to Athletic Trainers (AT's) who desire to bill insurance companies for services that they render under their respective state scope of practice.

There are multiple types of codes to consider when you consider the mechanics of billing for your services as an athletic trainer. This document will address and discuss CPT Codes, ICD-10 Codes, Revenue Codes, and will also address applicable modifiers.

Overview of Current Procedural Terminology (CPT) Coding System

The CPT coding system describes medical, surgical, and diagnostic services performed by physicians and other health care professionals. The coding system, developed and maintained by the American Medical Association (AMA), offers health care providers "a uniform process for coding medical services that streamlines reporting and increases accuracy and efficiency." CPT codes are not the same as ICD-10 codes. While CPT codes are similar to ICD-10 codes, CPT codes identify services rendered, whereas ICD-10 codes represent patient diagnoses. (For additional information on ICD-10 codes, please refer to the ICD-10: Understanding the Basics document).

The Centers for Medicare and Medicaid Services (CMS) uses the CPT coding system to establish reimbursement to Medicare providers. Each CPT code has a relative value unit (RVU) assigned to it, a rate that is reviewed every few years. RVUs are the standard measurement in analysis of reimbursement and payer contracts, physician compensation and productivity, and practice staffing and operating costs. Medicare fee schedules are based on RVUs. The majority of commercial insurers base their reimbursement levels on either the Medicare fee schedule or RVUs. It is important for athletic trainers (ATs) to understand how insurers reimburse health care providers for services rendered. Insurers generally pay health care professionals for services based on submission of a claim using one or more specific CPT codes. The calculation of a code's RVU is simpler than it seems. Below is the formula used to calculate payments for furnished services:

- (**Physician Work RVU** [Relative time and intensity to provide a service] **x Geographical Practice Cost Indices (GPCI)** [Accounts for geographic differences in the cost of practice across the country]) **+**
- (**Practice Expense RVU** [Costs of maintaining a practice, including rent, equipment, supplies, and non-physician staff costs] **x Practice Expensive GPCI**) **+**
- (**Malpractice RVU** [Represents cost of professional liability expenses] **x Malpractice GCPI**) = **Total RVU**.
- Then, **Total RVU x Conversion Factor** = **Allowable reimbursement**.

Commonly Used CPT Codes and Modifiers

The following list of CPT codes and commonly used modifiers is in no way exhaustive and represents the codes and modifiers most often used in clinical practice by ATs. For complete descriptions and listing of all current CPT codes, and their modifiers, please refer to Centers for Medicare & Medicaid Services page or the most recent official American Medical Association (AMA) CPT Code Book with rules and guidelines from the AMA's CPT Editorial Panel, as well as other resources commonly found on the internet.

"Throughout the CPT code set, the use of terms such as "physician," "qualified healthcare professional", or "individual" is not intended to indicate that other entities many 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 qualified healthcare professional is providing.
- Documentation must be appropriate to support the CPT code that is utilized. If not properly documented, the code will be denied.

ATHLETIC TRAINING EVALUATION CODES

- 97169 Athletic Training evaluation, low complexity
- 97170 Athletic Training evaluation, moderate complexity
- 97171 Athletic Training evaluation, high complexity
- 97172 Athletic Training re-evaluation

The level of the athletic training evaluation performed is dependent on clinical decision-making and the nature of the patient's condition (severity). See the Athletic Training Evaluation Coding Guide for more specifics on the description of each code and the assignment of complexity. It should be noted that the language for each level of complexity is identical regardless of whether a PT, OT or AT renders the evaluation. The CPT code number is simply different.

Athletic training evaluations include a patient history and an examination with the development of the plan of care, conducted by the physician or other qualified health care professional.

Coordination, consultation, and collaboration of care with physicians, other qualified health care professionals, or agencies is provided consistent with the nature of the problem(s) and the needs of the patient, family, and/or other caregivers.

At a minimum, each of the following components must be documented in order to report the selected level of athletic training evaluation. Athletic training evaluations include the following components:

- History and physical activity profile
- Examination
- Clinical decision making
- Development of plan of care

PHYSICAL MEDICINE & REHABILITATION CODES

The application of a modality that does not require direct (one-on-one) patient contact.

- 97012 Mechanical traction
- 97014 Electrical Stimulation unattended

The application of a modality that requires (one-on-one) patient contact.

- 97032 Electrical stimulation attended, manual, each 15 minutes
- 97033 Iontophoresis
- 97035 Ultrasound therapy, each 15 minutes

Physician or other qualified health care professional (ie, therapist) required to have direct (one-on-one) patient contact (in addition to the codes listed above).

- 97110 Therapeutic exercises, each 15 minutes
- 97112 Neuromuscular reeducation, each 15 minutes
- 97113 Aquatic therapy
- 97116 Gait training therapy, each 15 minutes
- 97140 Manual therapy 1/> regions, each 15 minutes
- 97530 Therapeutic activities, each 15 minutes
- 97545 Work hardening/conditioning; initial 2 hours
- 97546 Work hardening; each additional hour
- 97750 Physical performance test or measurement, with written report, each 15 minutes
- 97760: Orthotic management and training, initial orthotic encounter, each 15 minutes
- 97761: Prosthetic training, initial encounter, each 15 minutes
- 97763 Orthotic/prosthetic management and/or training, subsequent encounter, each 15 minutes
- 90150 Group Therapy

BIOFEEDBACK SERVICES AND PROCEDURES

- 90901 Biofeedback

APPLICATION OF CASTS AND STRAPPING

For use where medically necessary for return to activities of daily life, not recommended for maintenance therapy or return to sport.

- 29240 Strapping; shoulder
- 29260 Strapping; elbow or wrist
- 29280 Strapping; hand or finger
- 29520 Strapping; hip
- 29530 Strapping; knee
- 29540 Strapping; ankle and/or foot

- 29550 Strapping; toes
- 29580 Unna boot
- 29581 Application of multi-layer compression system; leg (below knee) including ankle & foot
- 29582 Compression system; thigh and leg, including ankle and foot, when performed
- 29583 Compression system; upper arm and forearm
- 29584 Compression system; upper arm, forearm, hand and fingers

HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) LEVEL II CODES

The HCPCS coding system is divided into two levels. Level I of the HCPCS is comprised of CPT codes. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, suppliers, and services not included in the CPT code set jurisdiction. For more information on the HCPCS coding system, please refer to Centers for Medicare & Medicaid Services page.

- A6441-A6457 Bandages/dressings
- E0110-E0118 Crutches
- E0720-E0770 TENS
- E1800-E1841 Orthopedic devices
- L1500-L2999 Orthotic devices
- L3650-L4130 Orthotic devices

HCFA 1500 CLAIM FORM

A HCFA 1500 form is the official standard form that is used by physicians as well as other providers when submitting claims or bills for reimbursement to private insurers as well as managed care plans for health services. HCFA 1500 also is used to bill Medicare and Medicaid for health services.

UB 04 CLAIM FORM

UB 04 is a billing format adopted by the National Uniform Billing Committee (NUBC). The NUBC is a voluntary committee chaired by the American Hospital Association (AHA) with representation by national provider and payer organizations. The UB 04 is the billing format utilized by all hospitals when submitting claims or bills for reimbursement.

UB 04 Revenue Codes used by ATs in Hospitals

- 0940 Other Therapeutic Services
- 0951 Athletic Training

MODIFIERS

In general, AT's who currently bill will not use modifiers as they are assigned by Medicare and AT's currently are not a covered provider by Medicare.

Modifiers can be two digit numbers, two character modifiers, or alpha-numeric indicators. Modifiers provide additional information to payers to ensure the health care provider is paid correctly for

services rendered. The modifiers listed below are a sample of commonly used modifiers which should be understood by ATs. Please refer to Centers for Medicare & Medicaid Services page for additional modifiers and their explanation.

- GP- Used to tell Medicare that you are billing for services provided as part of an outpatient physical therapy plan of care
- 25- Used when performing and billing for a re-evaluation and treatment on the same day. (Medicare functional outcomes).
- KX- Used when Medicare patient has exhausted their benefits for rehab services. The clinician is "certifying that the services rendered are medically necessary". Documentation must demonstrate medical necessity.