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LOCKING IT DOWN: PART 2

BY LON KILGORE Proponents of regulation fail to recognize the barriers to linking personal training to health care and third-party insurance payments.

Dave Re/CrossFit Journal

When people have limited function due to injury or disease, those in clinical-exercise occupations such as physical therapy, athletic training and exercise physiology return them to normal function.

Mike Warkentin/CrossFit Journal

Licensing proponents have little connection to personal training and instead link improved health with increased physical activity, which can be as simple as a sedentary individual's deciding to rake the lawn.

As detailed in "Locking It Down," the benefits of legislated licensing for personal training are minimal at best for both the public and personal trainers.

So why would personal trainers want their occupation to become a licensed profession?

Many don't, and many more haven't even considered the issue. The stark reality is personal trainers are not driving the boat. If licensure comes to fruition, it's more likely that credit—or blame—will be assigned to an organization unrelated to personal training. These organizations are not interested in helping personal trainers succeed; they are interested in regulating personal trainers for financial gain related to licensing or training prior to licensing.

The primary example of this craven quest for legislated income is the United States Registry of Exercise Professionals (USREPS, established by the Coalition for the Registry of Exercise Professionals), whose business model requires you to pay for registration to be on its list of personal trainers. To be eligible for the list, you must complete training and certification through a program accredited by the National Commission for Certifying Agencies. Of course, USREPS member organizations—most notably the American College of Sports Medicine (ACSM) and the National Strength and Conditioning Association (NSCA)—provide that training and certification.

Should such organizations gain oversight of personal training through legislation, the result would be regulation by a government-appointed body that does not represent the vast majority of personal trainers. These organizations are also unfamiliar with the day-to-day realities of working in the fitness industry—clinical exercise and strength and conditioning for sports are not personal training.

How can we say the ACSM and NSCA do not represent personal trainers? It's in their mission statements. Or, rather, it's not in their mission statements:

"The American College of Sports Medicine advances and integrates scientific research to provide educational and practical applications of exercise science and sports medicine," according to the ACSM website.

"The National Strength and Conditioning Association was founded in 1978 with 76 strength coaches from across the country with the common desire to network, collaborate and unify the profession of strength and conditioning," according to the NSCA website.

HEALTH-PLOITATION

In their pursuit of legislation mandating licensure, organizations with financial interest in licensing will spend considerable time and money to position themselves as the authoritative body and their members as agents of authority with respect to professional conduct and standards. Because these groups are not involved with personal training, the standards will be those of clinical exercise and detached academia.

These standards will not be sufficiently informed by personal trainers and those invested in the vocational education of personal trainers, and they will not allow the diversity of exercise systems currently in use today to continue operation. In short, imposed standards will create a narrow gate through which all must pass.

> Key byproducts of professional licensing: The financial well-being of a group is protected and competition is limited.

Key to the push for licensing is data that correlates increased physical activity—not exercise as delivered by personal trainers—with improved health, defined as the absence of disease or reduction in disease frequency.

Linking licensing to health is a clever tactic. The more closely licensed personal training is tied to health care and medicine, the greater the opportunity for practitioners to charge for their services as part of third-party insurance schemes. Linking trainers to health status improves the chances that the membership of the sponsoring organization can be part of these schemes.

Certain groups are indeed implementing this strategy. According to the USREPS website, the group is working to convince the U.S. Department of Labor to move personal training from the Personal Care and Service Occupations category to Healthcare

IF CLAIMING IN-PATIENT CARE, PLEASE INDICATE SERVICE DATES

SERVICE DATE(S)	YEAR	MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18

PROCEDURE/TREATMENT	FEE CODE	FEE	DATE OF SERVICE (YEAR MONTH DAY)	TIME
Back squats	**?**	**?**	**15/07/15**	**9 a.m.**
Lunges	**?**	**?**	**15/07/15**	**9 a.m.**
Deadlifts	**?**	**?**	**15/07/15**	**9 a.m.**
Front squats	**?**	**?**	**15/07/15**	**9 a.m.**
Romanian deadlifts	**?**	**?**	**15/07/15**	**9 a.m.**

DIAGNOSIS AND OTHER REMARKS

Patient's leg strength lacking. Standard strength training recommended.

CLAIM INVOLVES:

- [ ] WORKERS' COMPENSATION
- [ ] PENSIONABLE DISABILITY
- [ ] AUTOMOBILE ACCIDENT
- [x] OTHER THIRD PARTY

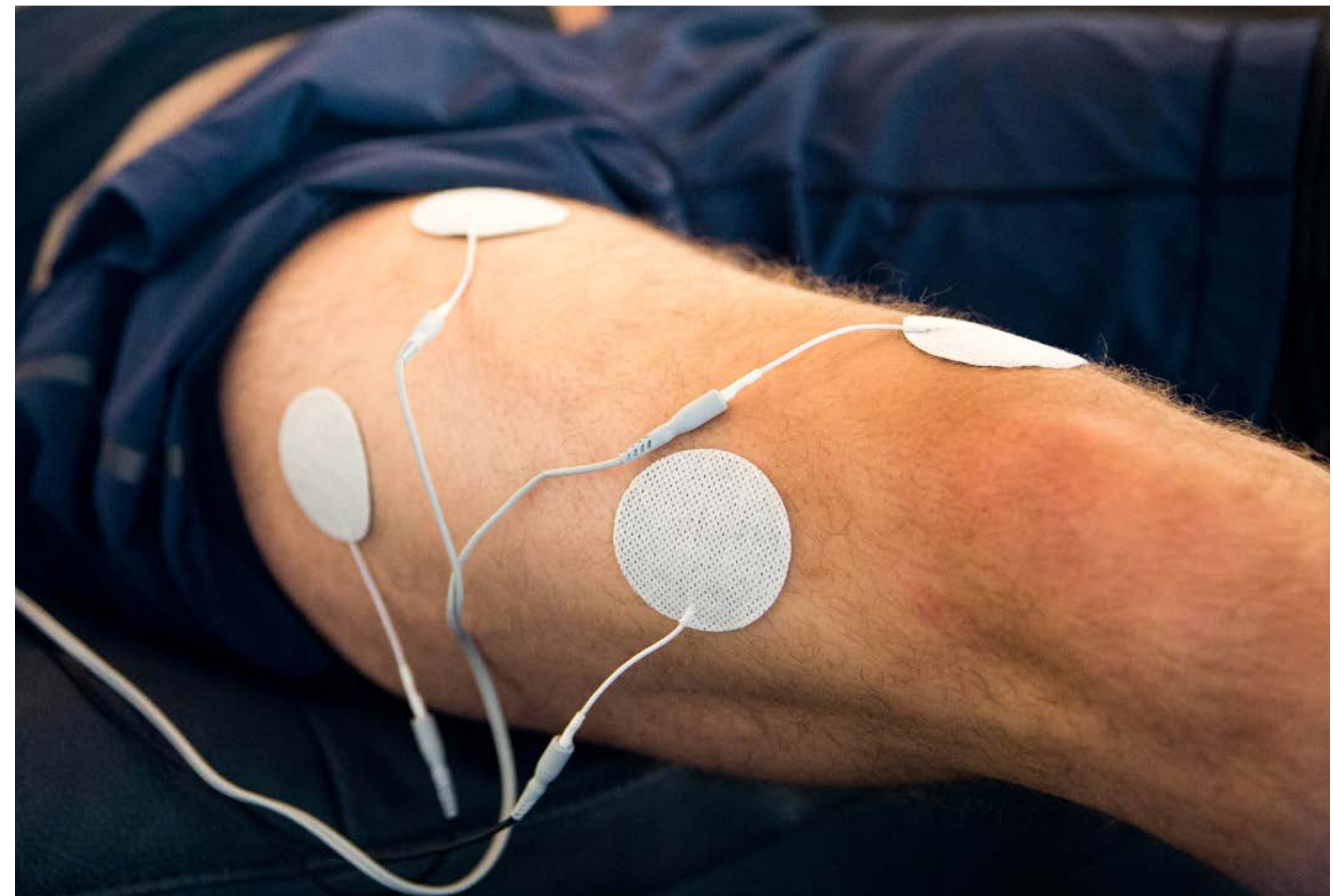
- [x] PAY PHYSICIAN/PRACTITIONER
  I accept the patient's plan payment as payment in full
- [ ] PAY PATIENT

PHYSICIAN'S/PRACTITIONER'S SIGNATURE: *Joe Trainer*

DATE

Staff/CrossFit Journal

Licensure of fitness trainers will provide no guarantee that practitioners will be able to access third-party insurance networks.



Dave Re/CrossFit Journal

It took 35 years of lobbying for athletic therapy to become recognized as an allied health profession.

Practitioners and Technical Occupations.

"The opportunity to affect change on the job reclassification of our industry comes at a very appropriate time as we actively work to become an integral part of the health care continuum," the USREPS site explains.

Remember that USREPS' main members are the ACSM and NSCA.

Attempting to sell personal training as another clinical occupation that uses exercise as a featured therapy will likely start a hotly contested turf war. Existing health and medical professional bodies do not readily accept new kids on the block, and they actively prevent new competitors from unfettered access to the feeding trough that is insurance reimbursement.

These are key byproducts of professional licensing: The financial well-being of a group is protected and competition is limited.

TURF WARS

An example of protectionism can be seen in the lengthy dispute between the American Physical Therapy Association (APTA) and the National Athletic Trainers Association (NATA). The conflict regarding scope of practice began in 1974 and did not end until 2009 through arbitration.

Athletic training originated in the late 19th century as conditioning coaches worked to keep track athletes participating through a variety of methods including rubbing muscles, applying counter-irritants, wrapping body parts and using various home remedies. No education was required to be an athletic trainer; you learned by watching and doing. In the early history of athletic training, the first journal for athletic trainers seemed to define the nature of the occupation at the time with its name: The First Aider.

Athletic trainers have steadily expanded their scope of practice over time to include therapeutic exercise and rehabilitation, intruding heavily into the scope of practice for physical therapists. The APTA took umbrage and sought to exclude athletic trainers from provision of manual therapies, maintaining that this practice was the sole domain of physical therapists.

Such discrimination was odd, as modern physical therapy originated with many of the same influences as athletic training. At the end of the 19th century and in the early 20th century, orthopedic surgeons often recruited women trained in physical education to deliver remedial exercise to patients. At the time, these physical-therapy workers were called "reconstruction aides." The difference between athletic trainers and physical therapists seems to be that one worked with athletes and the other with the sick and injured.

In the early 20th century, the importance of rehabilitating wounded soldiers and those stricken with polio created a developmental divergence between the two occupations. The relevance of physical therapy to national defense and national health led the U.S. Surgeon General to establish the Division of Special Hospitals and Physical Reconstruction in 1918, as well as a school for physical therapy at Walter Reed Army Hospital. This formalized recognition of the profession and codified the education required for entry. The existence of athletic training as a small and peripheral support occupation for organized sport did little to raise awareness of the occupation or establish a robust preparatory path to practice.

In 1955, the NATA appointed a Committee on Gaining Recognition to change the image of athletic trainers from that of water boys and ankle tapers to that of medical or health professionals. In 1959, some athletic-training information was introduced into university physical-education curricula, and athletic training was taught as a minor until the 1980s. In fact, there has long been an option that requires generic university instruction and internship hours under a certified athletic trainer for qualification.

In 1969, the Committee on Gaining Recognition changed its name to the Certification Committee, and in 1970 the first certification exam for athletic trainers was offered. As athletic trainers expanded their operations off the field, physical therapists countered in 1974

with the creation of the Sports Physical Therapy Section (SPTS), a division of the APTA.

Thirty-five years of persistent lobbying and expansion of scope of practice by athletic trainers led the American Medical Association (AMA) to recognize athletic training as an allied health profession in 1990. But the path to being able to participate in third-party reimbursement schemes was still incomplete.

The APTA's view of athletic trainers diverged from the AMA's and was published in 1993 in "Athletic Trainer Utilization in Sports Medicine Clinics." In brief, the article said athletic trainers working in clinical environments should be subservient to physical therapists (3). In this scenario, physical therapists would employ athletic trainers in their clinics. Athletic trainers would provide services under the supervision of physical therapists, and physical therapists would receive third-party payments.

After many years of posturing, the NATA in 2008 filed an anti-trust suit against the APTA in the United States District Court for the Northern District of Texas, Dallas Division, alleging monopolistic behavior. After legal expenditures on both sides, the APTA and NATA in 2009 entered into a legal agreement about the terminology and scope of practices that define each profession. But many of the issues about practice and who can access what forms of third-party reimbursement remain. The APTA FAQ about the settlement specifically states, "Athletic trainers are not qualified under Medicare to provide outpatient physical therapy services."

It's important to ask a question: If the APTA and NATA aggressively fought for the rights to deliver exercise for clinical purposes, would they not feel threatened if personal trainers begin claiming their scope of practice includes the use of therapeutic exercise to improve health and treat disease?

The turf war over scope of practice and access to third-party reimbursement for physical-therapy and athletic-training services might seem like much ado about nothing. It is, in fact, a big deal, as reimbursement creates a large and consistent revenue stream.

However, becoming eligible to participate in third-party reimbursement schemes is nuanced and difficult. For any exercise occupation wishing to become eligible, a major hurdle must be cleared:

"Most insurance/managed care contracts are filed with the state declaring whom the company will reimburse for services. A large number of these organizations list 'licensed health care professionals' as the only reimbursable entities," according to the NATA.

To be part of the insurance combine, it is obvious that being recognized as a licensed health-care profession is required. As such, it was critical for the NATA to receive a meaningful endorsement (from the AMA) that legitimized athletic training as a health profession. In terms of expanded scope of practice, it was also imperative for athletic trainers to be able to operate in medical and health-care environments without infringing on an existing profession (physical therapy).

WHAT THIS MEANS TO THE FITNESS INDUSTRY

The ACSM espouses the mantra "exercise is medicine," which is suggestive that the ACSM—like the NATA before it—is interested in identifying as a health-care profession and inserting its organization and certified members into the third-party-reimbursement pathway. The NSCA also has a special-interest group promoting exercise as medicine. Other fitness organizations present similar fronts, and there's even an organization that proposes hospitals deliver "medical fitness" in the form of fitness training.

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But in the world of everyday working personal trainers—certified or uncertified—any movement toward licensure and recognition as a medical or health profession will be problematic.

Why? Most insurers have the reimbursable category "physical therapy"—not athletic training or personal training. Athletic trainers have gained limited recognition in delivering some services within the physical-therapy category.

Mike Warkentin/CrossFit Journal

Participation in third-party reimbursement schemes—with their attendant red tape and bureaucracy—would increase the cost of operating a gym.

THE HARD TRUTH

Do the public, legislative bodies and, more importantly, insurers believe a personal trainer provides any medical care?

Medicine is generally defined as a substance or preparation used in treating disease or the treatment of disease or injury by non-surgical means. Medicine is intended to be curative. While being fit is definitely associated with lower mortality rates and improved quality of life, it has not been shown to be a curative agent for any disease. A person seeks medical care when he's ill or injured; he doesn't go to the gym hoping for a cure for an infection, a remedy for a broken leg or an answer to any of the leading causes of death in the U.S.

Exercise can be treated as a prophylactic measure: It maintains the body so it can function properly and resist injury, and it's generally accepted that exercise can slow the onset or progression of numerous disease processes. This is the most medicine-like fitness can be: a preventive measure but not a cure.

Even if personal training does become a commonly licensed occupation, it is unlikely the public or the body politic will assign medical responsibility to or acknowledge medical competency in personal trainers—unless, like the NATA did for athletic trainers, some organization systematically reorganizes and reinvents personal training by altering the identity, duties and scope of practice to include clinical tasks. As it did with the NATA, such a change would likely take decades of lobbying, although the ACSM and NSCA, through USREPS, hope to accomplish the task by 2018.

Without the unlikely acknowledgement of personal training as a health or medical profession, and without a revision to third-party reimbursement policies, personal trainers will not be eligible for the revenue stream treasured by current exercise

Whether regulated oversight is from a physician, physical therapist, athletic trainer, occupational therapist or nurse, it is unlikely his or her training, experience and scope of practice actually prepare him or her to oversee personal-trainer activities (1,2).

and academic organizations. Licensure is the easy part of the equation, and it will be an empty gesture with heavy costs if it comes to pass.

All too often, personal trainers are led to believe licensure will ensure their work will be billable to insurance companies and annual incomes will rise. But it should be common sense that you cannot bill an insurance company for work with healthy individuals—even under the guise of preventive medicine. At best, only fitness testing might be considered a billable expense for the vast majority of fitness trainees, much like periodic dental check-ups. This possibility might be great for exercise physiologists but not for personal trainers who produce improvements in fitness and quality of life. However, nothing is certain. Currently, the Affordable Care Act does not list any exercise, fitness or physical-activity services as preventive and reimbursable.

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Although personal training is unlikely to be considered a health or medically associated occupation, that does not mean the work of personal trainers cannot or will not be claimable as health or medical service. Physicians, athletic trainers or physical therapists could employ personal trainers, and their services could theoretically be billed within a third-party reimbursement scheme. Physical therapists already employ physical assistants in this manner.

In this scenario, a personal trainer would not be an independent operator. Some form of oversight would be required, whether from a physician, physical therapist or even an athletic trainer. That would be a rather dire step backward from the American Dream for every gym owner and independent personal trainer.

Licensing of personal trainers could easily create this outcome. Just look at the supervisory path in new but currently unenforced legislation in Washington, D.C.: Omnibus Health Regulation Amendment Act of 2013. The law empowers the State Board of Physical Therapy as the regulatory body for personal trainers. So if the law is eventually enforced—it's currently under review due to widespread confusion—a clinically trained profession will oversee a different and non-clinical occupation.

It would be tempting to blame this silly arrangement on uncertainty and fragmentation in the fitness industry or the stereotypical assumption that personal trainers are all meatheads and aerobic dancers, but the situation is a result of definitions and published scope of practice. Personal training has few definitions and a very poorly elaborated scope of practice. Physical therapists, on the other hand, define themselves as follows on the APTA About Us page:

"Physical therapists are highly-educated, licensed health care professionals who can help patients reduce pain and improve or restore mobility."

The APTA scope-of-practice description also states:

"In addition, PTs work with individuals to prevent the loss of mobility before it occurs by developing fitness- and wellness-oriented programs for healthier and more active lifestyles."

This description seems akin to what a personal trainer does, and as such, personal training fits under physical therapy.

Is there a dedicated body of personal trainers that can effectively argue against this hierarchy? To date only CrossFit Inc. has stood up to represent personal trainers. CrossFit aggressively defends the rights of its trainers and coaches to practice, but its work also indirectly helps personal trainers with any credential by ensuring they are not misrepresented and regulated by organizations that have no right to do so.

Still, a regulatory precedent has been set. If licensing legislation proliferates and the D.C. documents are used as a template, personal trainers will be forced into the same position athletic trainers fought to escape for several decades: They'll be fighting for the right to work and supervise themselves. ■

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Lon Kilgore graduated from Lincoln University with a B.S. in biology and M.S. in kinesiology from Kansas State University, and he earned a Ph.D. from the Department of Anatomy and Physiology at Kansas State University's College of Veterinary Medicine. He has competed in weightlifting to the national level since 1972 and coached his first athletes from a garage gym to national-championship event medals in 1974. He has also competed in powerlifting, the first CrossFit Total event, wrestling and rowing. He has worked in the trenches, as a coach or scientific consultant, with athletes from rank novices to professionals and the Olympic elite, and as a collegiate strength coach. He was co-developer of the Basic Barbell Training and Exercise Science specialty seminars for CrossFit (mid-2000s). He was a certifying instructor for USA Weightlifting for more than a decade and a frequent lecturer at events at the U.S. Olympic Training Center. He is a decorated military veteran (sergeant, U.S. Army). His illustration, authorship and co-authorship efforts include the best-selling books "Starting Strength" (first and second editions) and "Practical Programming for Strength Training" (first and second editions), "Anatomy Without a Scalpel," "FIT," and recent release "Deconstructing Yoga," magazine columns, textbook chapters, and numerous research-journal publications. His professional goal is to provide the best quality, most practical, most accessible and highly affordable educational experiences to fitness professionals through his university work and through his curriculum-development work for universities and for continuing education for the fitness industry. His students have gone on to become highly notable figures in weightlifting, powerlifting, cycling, coaching, fitness and academia.