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Eli's Rehab Report

READER QUESTIONS: Billing an Eval? See What Else You Can Bill

Question: I just returned to practice after several years off. I read the Reader Question in Vol. 10, No. 7 about billing a therapy evaluation code and a wheelchair assessment code (97542) on the same claim. This has led me to question whether I can bill for both a regular evaluation (97001) and a treatment on the same day.

For example, a patient comes into my clinic for an evaluation, and he is experiencing intense pain. Ethically, I don't want to just do an eval and send him home, so I put him on heat and e-stim (97014). In cases like this, I have been billing only for the eval because I'm under the impression that Medicare won't pay for both the eval and a treatment on the same day. Am I correct in doing this?

This leads to another question: As a PT in Texas, I am required to do a re-evaluation every 30 days. When I practiced several years ago, Medicare would only pay for the cheaper of the charges when a treatment was done on the same day as a re-eval. (Usually the re-eval was cheaper.) Is this still the case? I have been doing the paperwork for the re-evals to satisfy my state law but have not billed for them since they bring less reimbursement.

Instead I bill just for the treatment code. Is this OK, or do I legally need to bill for all services rendered, including the re-eval?

-" Texas subscriber.

Answer: As for your first question, Medicare and most other payers pay for evaluation and treatment on the same day. So don't hesitate to bill for your evaluations. Just be sure, as always, that your documentation supports the interventions provided.

When you do need to worry about billing two procedures on the same day is if Medicare created a CCI edit for the two CPT codes you want to bill together. In that case, if your procedures were legitimate, and if the edits allowed you to "unbundle" the procedures with a modifier, you could bill the two codes with a modifier 59 (Distinct procedural service). For example, physical therapy re-evaluation (97002) is considered a component of just about every other CPT code in the 97012-97762 range and is not separately reimbursed when provided on the same day as the other interventions. But if you provided the re-evaluation at a separate and distinct time and your documentation supports it, you could bill 97002 on the same day and append modifier 59 to 97002 on the claim form. Then you'd be reimbursed for both the PT reevaluation and other interventions that you provided that day under Medicare Part B benefits.

Regarding your question on re-evaluations, payers do not consider a re-evaluation necessary simply because your state practice act requires it every 30 days. So it would have to meet the payer's coverage criteria to submit a claim. If, however, your re-eval is covered by insurance, the therapist can bill this with other treatments on the same day.

If the re-eval doesn't meet insurance reimbursement criteria and you do the re-eval only because your practice act requires it, you are not under obligation to bill for it.

There is no law that says you have to bill every service you provided.

-- Reader Questions were answered by **Rick Gawenda, PT,** director of PM&R at Detroit Receiving Hospital and President/CEO of Gawenda Seminars.

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