

Eli's Rehab Report

Reader Questions: Document, but Don't Bill, Re-Evals in Acute Care

Question: I work in an acute-care setting, and I'm wondering how and when my therapists can use the re-evaluation charge. Is there a different way to bill for re-evals in this setting than in other settings?

Texas Subscriber

Answer: Those in an acute-care setting do not get paid by CPT codes, so you couldn't report 97002

(Physical therapy re-evaluation) or 97004 (Occupational therapy re-evaluation) as a separate line item on the claim form. Instead, you're paid based on diagnostic related groups (DRGs), which means that, technically, what you do in terms of acute-care therapy will not get you any more money.

A few payers may reimburse you based on percent of charges, where in that case, the re-evaluation charge would impact your reimbursement, but the CPT code would still not appear on the claim form. That said, how you want to handle re-evals in the acute-care setting is up to you and your organization.

Refresher: Regardless of how you're reimbursed, if you want to do a re-eval, you should use the same criteria that a therapist in an outpatient setting would use, which is after a significant change in the patient's status.

For example, you see a patient, and he was transferred to the intensive care unit or critical care unit, and a couple days later the physician recommends therapy, and you go back in. You might consider that encounter a re-eval, and you would just note that in your documentation.