Eli's Rehab Report

Reader Question: 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 reevaluation charge. Is there a different way to bill for re-evals in this setting than in other settings?

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, and 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 who was transferred to the intensive care unit or critical care unit. A couple of 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.