Eli's Rehab Report

Reader Questions: PT Re-Eval Frequency Depends on Payer Rules

Question: How often can we report a physical therapy evaluation (**CPT 97001**) and re-evaluation (97002) for Blue Cross Blue Shield patients?

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Answer: The answer will depend on each state's BCBS payer guidelines. For example, Washington's provider, Regence BlueShield, states, "An evaluation is allowed once, per member, per condition and per tax ID. A re-evaluation is allowed once, every two weeks, per member, per condition and per tax ID." But many other state BCBS programs have their own frequency requirements for these codes.

Therefore, if your BCBS payer follows similar guidelines, you could report an evaluation for a new patient presenting with an order for PT due to back pain. Two weeks later, you can report a re-evaluation, if warranted, to determine whether the therapy has helped improve her condition.

If the patient injures her shoulder three weeks after that when she's lifting furniture, you can report another unit of 97001 to evaluate the new condition and develop a new plan of care for the shoulder injury. Two weeks later, you can report a claim for 97002 to re-evaluate the shoulder injury if it meets the re-evaluation definition.

Because Regence BCBS' policy refers to "once per condition," you should consider the separate injuries separate conditions that warrant different evaluations.

Remember: A patient's condition may require re-evaluation if the patient shows a significant increase or decline in function, and because of this, you need to re-assess the patient; add, change or delete goals; and/or adjust your plan of care. Your re-evaluation should include all the components of your initial evaluation and assess how the patient is functioning now compared to her initial evaluation.

Most payers do not reimburse a therapy re-evaluation just to document a patient's progress. There must be a need to perform the re-evaluation reflected in the documentation to support that charge.