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BY AAPC

Eli's Rehab Report

Time Spent Assessing Change Doesn't Always Warrant 97002

Know what a re-evaluation specifically entails

Knowing when you can charge Medicare for a re-evaluation is tricky business. You may think that the time you spend on a re-evaluation is cause enough to charge Medicare, but the regulations aren't that specific.

When objective deficits found during the initial evaluation affect the treatment plan, the PT usually goes back and looks at those areas. Because standard tests and measures to assess the change can take 15 minutes, you might be tempted to charge for this time.

The catch: Unfortunately, coding isn't that simple. Medicare has specific terms for processing the re-evaluation code, and you should know Medicare's requirements for payment.

Know What the Code Covers

Re-evaluation (**CPT 97002** , Physical therapy re-evaluation), according to Medicare, "provides additional objective information not included in other documentation."

"A re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment indicates a significant improvement or decline or change in the patient's condition or functional status that was not anticipated in the plan of care for that interval," Medicare adds. The main point to realize here is that there must be an improvement, decline or change in the patient's condition before your Medicare carrier will pay for a re-evaluation.

Tip: Some regulations and state practice acts require re-evaluation at specific intervals. But to receive Medicare payment, re-evaluations must meet Medicare coverage guidelines.

Understand Assessment

Another point of confusion comes up with the term "assessment." Physical therapy services/procedures include a "mini-assessment," which is not separately payable. Medicare defines "assessment" as requiring professional skills to gather data by observation and patient inquiry and may include limited objective testing and measurement to make clinical judgments regarding the patient's condition(s).

With this type of "assessment," the therapist determines changes in the patient's status since the last visit/treatment day. The therapist then decides whether she should modify the planned procedure or service and determines whether a more complete re-evaluation is necessary. "Routine weekly assessments of expected progress in accordance with the plan are not payable as re-evaluations," Medicare states.

Follow This Example

"In the case of same-diagnosis re-evaluations, a therapist may be seeing a post-stroke patient, say for abnormality of gait," says **Carl J. Byron, III, ATC-L, CPC, EMT-I, LHCA-C**, a consultant with Health Care Consulting Services Inc. "At the initial evaluation, the patient was alert and oriented to person, place, time and situation, and could speak normally with a slight slur, and could ambulate well enough to warrant skilled therapy gait training. But after three weeks during one visit, the patient was suddenly unable to put words together, and the gait was extremely poor with numerous falls."

In addition to sending the patient back to the referring physician because there is significant evidence of potentially another stroke, the therapist is warranted in conducting a re-evaluation because the patient's condition has changed, not

just significantly but dramatically. The therapist could use the re-evaluation information for a possible further referral to the doctor recommending a speech language pathologist, Byron says.

"The therapist would need to do a re-evaluation to determine how to safely proceed with skilled therapy at this point, or even if skilled therapy could be continued. The re-evaluation should contain all elements of the initial evaluation," Byron says. The therapist would bill 97002 and link it to a diagnosis, such as abnormality of gait (781.2).

Remember: Providers must understand that other insurance plans may have other coverage limits for re-evaluations, but Medicare only pays if there is a change in the patient's condition or functional status that was not expected in the care plan for that interval. For example, new clinical findings or failure of the patient to respond to the treatment outlined in the care plan, says **Rick Gawenda, PT**, director of physical medicine and rehabilitation at Detroit Receiving Hospital.