Tip of the Month

Re-evaluations

97164 and 97168

Common procedural terminology or CPT codes are the medical codes utilized by health professionals to describe the services performed and billed to their patients. As therapists, each of us has a list of codes we most frequently use, for example: 97110 for therapeutic exercises, 97535 for self care training, G0515 for cognitive training. Therapists mix and match codes in order to build a picture of the treatment plan and the techniques required to aid patients in meeting their goals.

A frequently underutilized and overlooked CPT code is the re-evaluation code. Physical and occupational therapy have distinct codes, 97164 and 97168, respectively, which are exclusive for re-evaluations. Speech therapists do not have a defined re-evaluation code. According to ASHA and CMS, the ST should bill the appropriate evaluation code when completing a re-evaluation under Medicare.

According to CMS, a re-evaluation is separately payable and periodically indicated during an episode of care when the professional assessment of a clinician 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. It is not a routine, recurring service, but focused on one of four components:

- Evaluation of progress toward current goals
- Making a professional judgment about continued care
- Modifying goals and/or treatment
- Terminating services

Indications for a re-evaluation include new clinical findings, a significant change in the patient's condition or failure to respond to the therapeutic interventions outlined in the plan of care. A formal re-evaluation is covered under CMS guidelines only if the documentation supports the need for further tests and measures after the initial evaluation.

Functional reporting (functional G-code and severity modifier) is also required when billing a re-evaluation code, just as it is required with an evaluation.

Examples of clinical reasons for billing a re-evaluation vs. a recertification:

Patient has a TIA and goes to the hospital, but returns to the facility within 24 hours exhibiting new symptoms of left side weakness, confusion, and pocketing food.

Patient had a fall in the facility resulting in a fracture of the L wrist not requiring surgical intervention but resulting in the patient unable to use the dominant UE for ADLs or mobilize wheelchair and front wheeled walker.

Centers for Medicare Services definition of re-evaluation codes

97164: Re-evaluation of a PT established POC, requiring these components: an examination including a review of history and use of standardized tests and measures is required; and a revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome.

97168: Re-evaluation of an OT established POC: requiring an assessment of changes in patient functional or medical status, along with a revised plan of care. An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals.