Clinical Practice Guideline: **Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations for Dates of Service Effective January 1, 2021 – December 31, 2022**

Date of Implementation: **January 21, 2021**

Scope: **Specialty**

A variety of Current Procedural Terminology (CPT) codes represent evaluation/re-evaluation services. The choice of the appropriate evaluation/re-evaluation code series is determined by practitioner licensure (Evaluation and Management (E/M) codes (e.g., DC, ND, DPM) or Evaluation and Re-evaluation codes (e.g., PT, OT, AT)).

Appropriate outcome measures (e.g., Oswestry Disability Index, Neck Disability Index, and Visual Analogue Pain Scale) are an integral part of most evaluations and re-evaluations. These tools allow the practitioner to quantify the patient's clinical and/or functional status, identify prognostic indicators, measure changes in clinical and/or functional status over time, and assess the effectiveness of interventions. Please refer to www.ashlink.com for additional information on various outcome assessment tools and other ASH Clinical Practice Guidelines.

OFFICE OR OTHER OUTPATIENT EVALUATION AND MANAGEMENT (E/M) CODING OVERVIEW

For specialties that use Office or Other Outpatient E/M codes, a New Patient is defined by the CPT codebook as one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. An Established Patient is defined by the CPT codebook as a patient who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. Practitioners are encouraged to become familiar with the current CPT codes and their use as well as with the applicable American Specialty Health – Specialty (ASH) client summaries.

According to the CPT codebook, E/M codes refer to Evaluation and Management services provided during the physician/qualified health care professional-patient interaction. The typically used E/M codes are Office or Other Outpatient Services for New Patients: 99202 – 99205 and for Established Patients: 99211 – 99215. Proper E/M coding is a requirement under the federal Health Insurance Portability and Accountability Act (HIPAA).

GUIDELINES FOR OFFICE OR OTHER OUTPATIENT E/M SERVICES

ASH follows the definitions and documentation requirements for coding Office or Other Outpatient services found in the currently applicable American Medical Association CPT codebook. Providers are encouraged to review changes to the definitions and documentation requirements for coding on an annual basis. Significant changes to Office or Other Outpatient E/M services coding and documentation requirements became effective January 1, 2021.

History and/or Examination

Office or Other Outpatient E/M services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination is determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information and the patient or caregiver may supply information directly (e.g., by portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of Office or Other Outpatient services.

Number and Complexity of Problems Addressed at the Encounter

One element in the level of code selection for an Office or Other Outpatient service is the number and complexity of the problems that are addressed at an encounter. Multiple new or established conditions may be addressed at the same time and may affect medical decision making. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not in itself determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

Instructions for Selecting a Level of Office or Other Outpatient E/M Service

Choosing the appropriate level of Office or Other Outpatient Services E/M code is based on one of two (2) components:

1. The total time for E/M services performed on the date of the encounter; or
2. The level of the medical decision making as defined for each service.

If the physician/other qualified health care professional submits documentation citing the amount of time spent on the E/M service on the date of the encounter and that time was used as the standard for the E/M code selected, ASH will evaluate the level of E/M code that was performed using the time guidelines as outlined in the CPT codebook.

If the physician/other qualified health care professional fails to identify whether total E/M time or medical decision-making criteria was the basis for the selection of the E/M level, and the total time of the E/M service performed on a specific date of encounter is not clearly documented in the medical record, the determination of the level of E/M service will default to medical decision-making criteria. If, in response this default determination, the physician/other qualified health care professional submits additional information in the form of a re-open/reconsideration request and provides amended documentation citing the amount of time spent on the E/M service on the date of the encounter and that time was used as the standard for the E/M code selected, ASH will re-evaluate the level of E/M code that was performed using the time guidelines as outlined in the CPT codebook.

TIME

In the CPT codebook, the American Medical Association provides guidance concerning using time as a factor for choosing the appropriate level of Office or Other Outpatient Services E/M codes.

Time may be used to select a code level in Office or Other Outpatient services whether or not counseling and/or coordination of care dominates the service.

When prolonged time occurs, the appropriate add-on code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Medical Decision Making

Medical decision making includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. Medical decision making in the office and other outpatient services code set is defined by three elements:

- The number and complexity of problem(s) that are addressed during the encounter.
- The amount and/or complexity of data to be reviewed and analyzed. This data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not separately reported. It includes interpretation of tests that are not separately reported. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Data is divided into three categories:
    - Tests, documents, orders, or independent historian(s). (Each unique test, order or document is counted to meet a threshold number);
    - Independent interpretation of tests;
    - Discussion of management or test interpretation with external physician or other qualified healthcare professional or appropriate source.
- The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic

procedure(s), treatment(s). This includes the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Four types of medical decision making are recognized: straightforward, low, moderate, and high. The concept of the level of medical decision making does not apply to code 99211.

Shared medical decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

Medical decision making may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report should not be counted in the medical decision making when selecting a level of Office or Other Outpatient service. When the physician or other qualified professional is reporting a separate service for discussion of management with a physician or other qualified health care professional, the discussion is not counted in the medical decision making when selecting a level of Office or Other Outpatient service.

The Levels of Medical Decision Making is clearly described in the AMA CPT codebook and should be used as a guide to assist in selecting the level of medical decision making for reporting an Office or Other Outpatient E/M service code. The AMS CPT codebook describes the four levels of medical decision making (i.e., straightforward, low, moderate, high) and the three elements of medical decision making (i.e., number and complexity of problems addressed, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management) and the elements required to qualify for a particular level of medical decision making. Definitions for the elements of medical decision making for Office or Other Outpatient E/M services are also found in the AMA CPT codebook.

The following tables are a comparison of all new patient and established patient Office or Other Outpatient E/M service codes:

New Patient

CPT Code	Medical Decision Making	History	Examination	Time
99202	Straightforward	Medically Appropriate	Medically Appropriate	15-29 minutes
99203	Low	Medically Appropriate	Medically Appropriate	30-44 minutes
99204	Moderate	Medically Appropriate	Medically Appropriate	45-59 minutes
99205	High	Medically Appropriate	Medically Appropriate	60-74 minutes

Established Patient

CPT Code	Medical Decision Making	History	Examination	Time
99211	n/a	n/a	n/a	Not Defined
99212	Straightforward	Medically Appropriate	Medically Appropriate	10-19 minutes
99213	Low	Medically Appropriate	Medically Appropriate	20-29 minutes
99214	Moderate	Medically Appropriate	Medically Appropriate	30-39 minutes
99215	High	Medically Appropriate	Medically Appropriate	40-54 minutes

MEDICAL NECESSITY CRITERIA FOR E/M SERIES CODES

Initial Evaluations (Use the appropriate E/M series code supported for each case)

An initial evaluation of a patient presenting for healthcare services is performed to:

- Provide the basis for determining the working diagnosis;
- Reveal the possible occupational, social and/or psycho-social issues that may impact care;
- Identify co-morbid or complicating factors; and
- Establish the basis for an initial plan of care including:
  - The need for additional diagnostic testing; and
  - The need for referral to other healthcare practitioner(s) for evaluation, management, co-management or coordination of care;
- Develop initial set of treatment goals.

Re-Evaluations (Use the appropriate Established Patient E/M series code supported for each case)

Established patient re-evaluation services are considered medically necessary when **ALL** of the following conditions are met:

- Re-evaluation is not a recurring routine assessment of patient status.
- The documentation of the re-evaluation includes all of the following elements:
  - An evaluation of progress toward current goals;
  - Making a professional judgment about continued care;
  - Making a professional judgment about revising goals and/or treatment or terminating services.

And any one of the following indications is documented:

- The patient presents with new clinical findings;
- There is a significant change in the patient's condition;
- The patient has failed to respond to the therapeutic interventions outlined in the current plan of care.

A re-evaluation is not considered medically necessary once it has been determined that the patient has reached maximum therapeutic benefit for services provided, unless there is/are valid reason(s) documented, as clarified above, for the re-evaluation service.

For specialty services, except Podiatry and Naturopathy, ASH typically does not provide prospective (pre-service) approval of established patient E/M services, or re-evaluations, to be rendered in the future due to the difficulty in establishing the point at which a patient's condition would have changed sufficiently to require a re-evaluation and the inability to identify and substantiate the necessary components which would define the E/M service level. If there is a future point at which the practitioner decides a re-evaluation is necessary based on a significant change in the patient's condition, a new injury/condition, a significant exacerbation of an existing condition, or a new functional deficit or abnormality; it is appropriate to submit documentation of those factors and provide new

examination findings for medical necessity verification of the need for that re-evaluation and a modified treatment plan. ASH can only approve an established patient E/M service with appropriate documentation, justifying the medical necessity of an established patient E/M service that has been received.

PROLONGED SERVICES WITH OR WITHOUT DIRECT PATIENT CONTACT (ON THE DATE OF AN OFFICE OR OTHER OUTPATIENT SERVICE) CODING OVERVIEW

Code 99417 is used to report prolonged total time (i.e., combined time with and without direct patient contact) provided by the physician/other qualified health care professional on the date of office or other outpatient services (i.e., 99205, 99215). Code 99417 is only used when the office or other outpatient service has been selected using time alone as the basis and only after the minimum time required to report the highest-level service (i.e., 99205 or 99215) has been exceeded by 15 minutes. To report a unit of 99417, 15 minutes of additional time must have been attained. Do not report 99417 for any additional time increment of less than 15 minutes.

The listed time ranges for 99205 (i.e., 60-74 minutes) and 99215 (i.e., 40-54 minutes) represent the complete range of time for which each code may be reported. Therefore, when reporting 99417, the initial time unit of 15 minutes should be added once the minimum time in the primary E/M has been surpassed by 15 minutes. For example, to report the initial unit of 99417 for a new patient (99205), do not report 99417 until at least 15 minutes of time has been accumulated beyond 60 minutes (i.e., 75 minutes) on the date of the encounter. For an established patient encounter (99215), do not report 99417 until at least 15 minutes of time has been accumulated beyond 40 minutes (i.e., 55 minutes) on the date of the encounter.

Time spent performing separately reported services other than the E/M service is not counted toward the time to report 99205, 99215 and prolonged services time.

Prolonged services of less than 15 minutes total time are not reported on the date of office or other outpatient service when the highest level is reached (i.e., 99205, 99215).

The following examples illustrate the correct reporting of prolonged services with or without direct patient contact in the office setting:

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	CPT Code(s)
Less than 75 minutes	99417 Not reported separately
75-89 minutes	99205 X 1 and 99417 X 1
90-104 minutes	99205 X 1 and 99417 X 2
105 minutes or more	99205 X 1 and 99417 X 3 or more for each additional 15 minutes

Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	CPT Code(s)
Less than 55 minutes	99417 Not reported separately
55-69 minutes	99215 X 1 and 99417 X 1
70-84 minutes	99215 X 1 and 99417 X 2
85 minutes or more	99215 X 1 and 99417 X 3 or more for each additional 15 minutes

EVALUATION MANAGEMENT FOR CONSULTATIONS AND MANAGEMENT

Office Consultations Overview

An office consultation is a type of E/M service provided at the request of another physician or appropriate source to either: 1) recommend care for a specific condition or problem; or 2) to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem. There is one set of codes for this service for new or established patients.

The practitioner must meet or exceed the three (3) out of three (3) key components of history, examination, and medical decision making for the office consultation 99241-99245 codes. Counseling and/or coordination of care with other practitioners or agencies should be provided consistent with the nature of the patient's problem(s) and the patient's and/or the patient's family's needs. This service requires the practitioner to have direct (face-to-face) contact with the patient and/or the patient's family.

The following information must be clearly documented in the patient's medical record: 1) request for a consultation from an appropriate source [e.g., referral letter]; 2) the reason[s] why a consultation is needed; 3) provision for a practitioner whose advice, opinion, recommendation, suggestion, direction, or counsel, etc., is requested for evaluating and/or treating a patient since that individual's expertise in a specific medical area is beyond the scope of knowledge of the requesting practitioner; 4) a written report of findings and recommendations from the consultant to the referring practitioner.

This service may **not** be used for: 1) another appropriately requested and documented consultation pertaining to the same or a new problem; 2) the repeat use of consultation codes; 3) any distinctly recognizable procedure or service provided on or following the consultation; 4) assumption of care (all or partial); 5) consultation prompted by the patient and/or the patient's family.

The extent of the **patient history** is dependent upon the nature of the presenting problems and clinical judgment. There are four types of history that are defined; *problem focused, expanded problem focused, detailed, and comprehensive.*

1. **Problem focused**: Chief complaint; brief history of present illness or problem.
2. **Expanded problem focused**: Chief complaint; brief history of present illness; problem persistent review.
3. **Detailed**: Chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family, and social history directly related to the patients' problems.
4. **Comprehensive**: Chief complaint; extended history of present illness; review of systems which is directly related to the problems identifies in the history of present illness plus a review of systems of all additional body systems; complete past, family and social history.

The extent of the **examination** performed is also dependent on the nature of the problem and clinical decision making. There are four types of examinations that are defined; *problem focused, expanded problem focused, detailed, and comprehensive.*

1. **Problem focused exam**: A limited examination of the affected body area or organ system.
2. **Expanded problem focused**: A limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
3. **Detailed**: An extended examination of the affected body areas and other symptomatic or related organ system(s).
4. **Comprehensive**: A general multi-system examination or a complete examination of a single organ system.

Medical decision making is an essential part and refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

1. The number of possible diagnoses and the number of management options.
2. The amount or complexity of medical records, diagnostic tests and other information.
3. The risk of serious complications, morbidity and mortality as well as comorbidities.

There are four recognized types of medical decision making: straightforward, low complexity, moderate complexity, and high complexity.

It should be remembered that Medical Necessity for the level of service chosen must be demonstrated. The actual performance of a *comprehensive* level of service does not justify the billing of a *comprehensive* service if the presenting complaint could have been managed adequately with a *detailed* or lower level of service.

It should also be remembered that it is the unusual case that presents with a condition that meets or exceeds *moderate* medical decision-making. In fact, typical cases, by their very nature as "typical," generally meet only *straightforward* clinical decision-making criteria. After gathering all this information, the practitioner can select the appropriate level of E/M service based on AMA CPT codebook requirements and guidance.

When a time override option is used, it must be appropriately and sufficiently documented in the medical record that the practitioner personally furnished the direct face-to-face time with the patient. Make sure that the start and end times of the visit are documented, along with the date of service.

New and Established Patients Office Consultation Codes

CPT Code	Presenting Problem	History	Examination	Clinical Decision-Making	Time
99241	Self-limited or Minor	Problem-Focused	Problem-Focused	Straightforward	15 minutes
99242	Low to Moderate	Expanded Problem-Focused	Expanded Problem-Focused	Straightforward	30 minutes
99243	Moderate	Detailed	Detailed	Low	40 minutes
99244	Moderate to High	Comprehensive	Comprehensive	Moderate	60 minutes
99245	Moderate to High	Comprehensive	Comprehensive	High	80 minutes

PROLONGED SERVICES WITH DIRECT PATIENT CONTACT (EXCEPT WITH OFFICE OR OTHER OUTPATIENT SERVICES 99202-99215) CODING OVERVIEW

Codes 99354 and 99355 are used when a physician/other qualified health care professional provides prolonged service(s) involving direct patient contact that is beyond the usual service in either the inpatient, observation or outpatient setting, except with office or other outpatient services (99202-99205 and 99212-99215). Direct patient contact is face-to-face and includes additional non-face-to-face services on the patient's floor or unit in the hospital or nursing facility during the same session. This service is reported in addition to primary procedure. Codes 99354 and 99355 are used to report the total duration of face-to-face time spent by a physician/other qualified health care professional on a given date providing prolonged service in the outpatient setting, even if the time spent by the physician/other qualified health care professional on that date is not continuous.

Code 99354 is used to report the first hour of prolonged services on a given date. This code may be used to report a total duration of prolonged services (add-on) of 30 – 60 minutes on a given date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported. 99354 must be used in conjunction with code 90837, 90847, 99241-99245, 99324-99337, 99341-99350, or 99483.

Code 99355 is used to report each additional thirty (30) minutes beyond the first hour (in addition to 99354). 99355 may be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately. 99355 may only be used in conjunction with code 99354. Code 99355 may be multiplied.

The following examples illustrate the correct reporting of prolonged services with direct patient contact in the office setting:

Total Duration of Prolonged Services	CPT Code(s)
<less than 30 minutes	Not reported separately
30 – 74 minutes (1/2 hour – 1 hr 14 min)	E/M code + 99354 x 1
75 – 104 minutes (1 hr 15 min – 1 hr 44 min)	E/M code + 99354 x 1 and 99355 x 1
105 minutes or more (1 hr 45 min or more)	E/M code + 99354 x 1 and 99355 x 2

Criteria for Using and Submitting Code 99354

1. The services meet the code 99354 duration requirement when the practitioner has spent an extra 30 to 74 minutes in addition to an outpatient E/M service such as Office Consultations (99241-99245). 99354 is not to be used with Office or Other Outpatient E/M codes 99202-99215.
2. Services must be Medically Necessary during the prolonged E/M service.
3. The duration and the content of the evaluation and management code must be documented in the medical record.

Examples of Improper Uses of Code 99354

1. Total physician direct patient contact services that is equal or less than the threshold time of the E/M service.
2. Time spent on rendering therapies or other services that are paid separately.
3. Services/activities conducted during the first thirty (30) minutes of E/M service.
4. Discussions that apply to non-covered service or conditions.
5. The time spent by office staff with the patient, or time that the patient remains unaccompanied in the office.
6. Inefficient application of clinical services that result in prolonged face-to-face time in the absence of documented necessity.

Criteria for Using and Submitting Code 99355

1. Time spent is supported by the clinical documentation that indicates the medical complexity and Medical Necessity.
2. Only to be used in conjunction with 99354.

MEDICAL NECESSITY CRITERIA FOR PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), AND ATHLETIC TRAINING (AT) EVALUATION AND RE-EVALUATION SERVICES

Evaluation

An initial evaluation for a new condition by a Physical Therapist, Occupational Therapist, or Athletic Trainer is defined as the evaluation of a patient:

- For which this is their first encounter with the practitioner or practitioner group;
- Who presents with:
  - A new injury or new condition; or
  - The same or similar complaint after discharge from previous care;
- Choice of code is dependent upon the level of complexity.

Relevant CPT Codes: CPT 97161, 97162, and 97163 – Physical Therapy evaluation, CPT 97165, 97166, and 97167 – Occupational Therapy evaluation, and CPT 97169, 97170, and 97171 - Athletic Training evaluation.

The evaluation codes reflect 3 levels of patient presentation: low-complexity, moderate-complexity, and high-complexity. Four components are used to select the appropriate PT evaluation CPT code. These include:

1. Patient history and comorbidities;
2. Examination and the use of standardized tests and measures;
3. Clinical presentation;
4. Clinical decision making.

Four components are used to select the appropriate OT evaluation CPT code. These include:

1. Occupational profile and client history (medical and therapy);
2. Assessments of occupational performance;
3. Clinical decision making;
4. Development of plan of care.

Four components are used to select the appropriate AT evaluation CPT code. These include:

1. History and physical activity profile;
2. Examination;
3. Clinical decision making;
4. Development of plan of care conducted by the physician or other qualified health care professional. Coordination, consultation, and collaboration of care with physicians, other qualified health care professionals, or agencies is provided consistent with the nature of the problem(s) and the needs of the patient, family, and/or other caregivers.

Codes and Descriptions for PT, OT, and AT Services

CPT Code	CPT Code Description
97161	Physical therapy evaluation, low complexity, requiring these components: ● A history with no personal factors and/or comorbidities that impact the plan of care; ● An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; ● A clinical presentation with stable and/or uncomplicated characteristics; and ● Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.

CPT Code	CPT Code Description
97162	Physical therapy evaluation, moderate complexity, requiring these components: ● A history with 1-2 personal factors and/or comorbidities that impact the plan of care; ● An examination of body system(s) using standardized tests and measures addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; ● An evolving clinical presentation with changing characteristics; and ● Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation, high complexity, requiring these components: ● A history with 3 or more personal factors and/or comorbidities that impact the plan of care; ● An examination of body system(s) using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; ● A clinical presentation with unstable and unpredictable characteristics; and ● Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97165	Occupational therapy evaluation, low complexity, requiring these components: ● An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; ● An assessment(s) that identifies 1-3 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and ● Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.

CPT Code	CPT Code Description
97166	Occupational therapy evaluation, moderate complexity, requiring these components: ● An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; ● An assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and ● Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97167	Occupational therapy evaluation, high complexity, requiring these components: ● An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; ● An assessment(s) that identify 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and ● A clinical decision-making is of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.
97169	Athletic training evaluation, low complexity, requiring these components: ● A history and physical activity profile with no comorbidities that affect physical activity; ● An examination of affected body area and other symptomatic or related systems addressing 1-2 elements from any of the following body structures, physical activity, and/or participation deficiencies; and ● Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 15 minutes are spent face-to-face with the patient and/or family.

CPT Code	CPT Code Description
97170	Athletic training evaluation, moderate complexity, requiring these components: ● A medical history and physical activity profile with 1-2 comorbidities that affect physical activity; ● An examination of affected body area and other symptomatic or related systems addressing a total of 3 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; and ● Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97171	Athletic training evaluation, high complexity, requiring these components: ● A medical history and physical activity profile, with 3 or more comorbidities that affect physical activity; ● A comprehensive examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; ● Clinical presentation with unstable and unpredictable characteristics; and ● Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.

The initial evaluation should document the necessity of a course of therapy through objective findings and subjective patient/caregiver self-reporting. Initial evaluations must be completed by the therapist or physician/non-physician practitioner that will be providing the therapy services. Initial evaluations are completed to determine the medical necessity of initiating rehabilitative therapy or skilled instruction in maintenance activities that the patient and/or caregiver can perform at home. The evaluation process assesses, for example, the severity and impact of the current problem, the possibility of multi-site or multi-system involvement, the presence of pre-existing systemic conditions (e.g., diseases), and the stability of the condition. If the patient presents with multi-system involvement and/or multiple site involvement, all pertinent areas/conditions should be assessed at the initial evaluation (i.e., cervical pain and knee pain; low back pain and rotator cuff irritation; cervical pain and low back pain).

Factors that impact the level of evaluation include the following:

- Patient's age
- Time since onset of injury/illness/exacerbation
- Mechanism of injury/illness/exacerbation
- Past medical and surgical history
- Co-morbidities and their impact on improvement
- Prior level of function

- Current level of function
- Status of current condition
- Patient's cognitive status and safety concerns
- Patient's level of motivation
- Patient's home situation (environment and family support)
- Objective examination findings
- Goals and goal agreement with the patient
- Rehab potential (prognosis) and probable outcome
- Expected progression of patient

Only one initial evaluation code should be used, and all presenting complaints and problems evaluated. If over the course of an episode of treatment, a new, unrelated diagnosis occurs, another initial evaluation may be covered. See *Physical Therapy Medical Policy/Guideline (CPG 135 – S), Occupational Therapy Medical Policy/Guideline (CPG 155 – S),* and *Athletic Training Medical Policy/Guideline (CPG 183 – S)* for more detail.

Providers/practitioners should consider the following points when billing for an evaluation:

- These evaluation codes are untimed, billable as one unit.
- Do not bill for a therapy initial evaluation for each therapy discipline on more than one date of service. If an evaluation spans more than one day, the evaluation should only be billed as one unit for the entire evaluation service (typically billed on the day that the evaluation is completed). Do not count as therapy "treatment" the additional minutes needed to complete the evaluation during the subsequent session(s).
- Do not bill range of motion (ROM) or physical performance tests and measurement codes (95851-95852, 97750, 97755, respectively). on the same day as the initial evaluation. The procedures performed are included in the initial evaluation codes and are not allowed by the Correct Coding Initiative (CCI) edits.
- Do not bill therapy screenings utilizing the evaluation codes. Screenings are not billable services.
- Evaluations for deconditioning after hospitalization where it is anticipated that prior functional abilities would spontaneously return through patient, caregiver and/or nursing activities are not considered medically necessary and are not covered.
- If treatment is given on the same day as the initial evaluation, the treatment is billed using the appropriate CPT codes. The documentation must clearly describe the treatment that was provided in addition to the evaluation.

Re-evaluation Services by Physical Therapist, Occupational Therapist or Athletic Trainer

Re-evaluations are distinct from therapy assessments. There are several routine reassessments that are not considered re-evaluations. These include ongoing reassessments that are part of each skilled treatment session, progress reports, and discharge summaries. Re-evaluation provides additional objective information not included in documentation of

ongoing assessments, treatment, or progress notes. Assessments are considered a routine aspect of intervention and are not billed separately from the intervention. Continuous assessment of the patient's progress is a component of the ongoing therapy services and is not payable as a re-evaluation.

Re-evaluation services are considered medically necessary when **ALL** of the following conditions are met:

- Re-evaluation is not a recurring routine assessment of patient status;
- The documentation of the re-evaluation includes all of the following elements:
  - An evaluation of progress toward current goals;
  - Making a professional judgment about continued care;
  - Making a professional judgment about revising goals and/or treatment or terminating services.

AND the following indication is documented:

- An exacerbation or significant change in patient/client status or condition.

Relevant CPT Codes: CPT 97164 – Physical Therapy re-evaluation, CPT 97168 – Occupational Therapy re-evaluation, and CPT 97172 Athletic Training re-evaluation

CPT Code	CPT Code Description
97164	Re-evaluation of physical therapy established plan of care, requiring these components: ● An examination including a review of history and use of standardized tests and measures is required; and ● Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: ● An assessment of changes in patient functional or medical status with 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; and ● A revised plan of care. A formal re-evaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family
97172	Re-evaluation of athletic training established plan of care requiring these components: ● An assessment of patient's current functional status when there is a documented change; and ● A revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome with an update in management options, goals and interventions. Typically, 20 minutes are spent face-to-face with the patient and/or family.

A re-evaluation is indicated when there is an exacerbation or significant change in the status or condition of the patient. Re-evaluation is a more comprehensive assessment that includes **ALL** of the components of the initial evaluation, such as:

- Data collection with objective measurements taken based on appropriate and relevant assessment tests and tools using comparable and consistent methods;
- Making a judgment as to whether skilled care is still warranted;
- Organizing the composite of current problem areas and deciding a priority/focus of treatment;
- Identifying the appropriate intervention(s) for new or ongoing goal achievement;
- Modification of intervention(s);
- Revision in plan of care if needed;
- Correlation to meaningful change in function; AND
- Deciphering effectiveness of intervention(s).

See *Physical Therapy Medical Policy/Guideline (CPG 135 – S), Occupational Therapy Medical Policy/Guideline (CPG 155 – S),* and *Athletic Training Medical Policy/Guideline (CPG 183 – S)* clinical practice guidelines for more detail.

Providers/practitioners should consider the following points when billing for a re-evaluation:

- Indications for a re-evaluation include an **exacerbation or significant change in patient/client status or condition.**
- When re-evaluations are done for a significant change or exacerbation in status or condition, documentation must show a significant improvement, decline or change in the patient's diagnosis, condition or functional status that was not anticipated in the current plan of care. The plan of care may need to be revised if significant changes are made, such as a change in the long-term goals.
- If a patient is hospitalized during the therapy interval, a re-evaluation may be medically necessary if there has been a significant change in the patient's condition which has caused a change in function, long term goals, and/or treatment plan.
- Therapy re-evaluations should contain all the applicable components of an initial evaluation and must be completed by a clinician.
- A re-evaluation is not a routine, recurring service. Do not bill for routine re-evaluations, including those done for the purpose of completing an updated plan of care, a recertification report, a progress report, or a physician progress report. Although some state regulations and practice acts require re-evaluations at specific intervals, for ASH payment, re-evaluations must meet ASH coverage guidelines.
- These re-evaluation codes are untimed, billable as one unit.
- Do not bill for re-evaluations as unlisted codes (97039, 97139, 97799), and/or with ROM or physical performance tests and measurement codes (95851-95852, 97750, 97755, respectively).

Medical Necessity Criteria for Speech Language Pathologist (SLP) Services Evaluation

Relevant CPT Codes: Speech/hearing evaluation (CPT codes 92521, 92522, 92523, and 92524)

CPT Code	CPT Code Description
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance

An evaluation for SLP services is indicated, reasonable and necessary for the clinician to perform to determine:

- If there is an expectation that the services will be appropriate for the patient's condition.
- The patient's level of function and is focused on identifying what the patient wants and needs to do, and on identifying those factors that help or hinder the performance of those activities.

During the first patient contact, the clinician evaluates and documents:

- A diagnosis (where allowed by scope of practice) and description of the specific problem to be evaluated and/or treated. This should include the specific body area(s) evaluated. Include all conditions and complexities that may impact the treatment. A description might include, for example, the pre-morbid function, date of onset, and current function;
- Objective measurements, preferably standardized patient assessment instruments and/or outcomes measurement tools related to current functional status, when these are available and appropriate to the condition being evaluated;
- Clinician's clinical judgments or subjective impressions that describe the current functional status of the condition being evaluated, when they provide further information to supplement measurement tools; and
- A determination that treatment is not needed, or, if treatment is needed a prognosis for return to pre-morbid condition or maximum expected condition with expected time frame and a plan of care.

In addition to the general information above, the evaluation includes the identification, assessment, diagnosis, and evaluation for disorders of: speech, articulation, fluency, and voice (including respiration, phonation, and resonance); language skills (involving the parameters of phonology, morphology, syntax, semantics, and pragmatics, and including disorders of receptive and expressive communication in oral, written, graphic, and manual modalities); and cognitive aspects of communication (including communication disability and other functional disabilities associated with cognitive impairment).

Re-evaluations

Previously CPT Code: Current Procedural Terminology does not define a re-evaluation code for speech language pathology; and thus, the evaluation code should be used. Currently a HCPCS Code: S9152 defines a Speech therapy, re-evaluation. This service is not separately priced by Medicare part B (e.g., services not covered, bundled, used by part A only, etc.), however some insurance companies may recognize it. Regardless, the documentation should differentiate between evaluation/re-evaluation and screening. Screening assessments are non-covered.

A re-evaluation is the re-assessment of the patient's performance and goals, after an intervention plan has been instituted, in order to determine the type and amount of change in treatments if needed. A re-evaluation may be indicated during an episode of care when a significant improvement, decline, or change in the patient's condition occurs. Re-evaluation requires the same professional skill as evaluation.

The decision to provide a re-evaluation shall be made by the clinician making a professional judgment about continued care, modifying goals and/or treatment or terminating services. A formal re-evaluation is covered only if the documentation supports the need for further tests and measurements after the initial evaluation. Re-evaluations are usually focused on the current treatment and may not be as extensive as initial evaluations. Re-evaluations may be appropriate at a planned discharge.

Continuous assessment of the patient's progress is a component of ongoing therapy services and is not a re-evaluation. A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services. Infrequent re-evaluations of maintenance programs may be covered when deemed necessary, if they require the skills of the SLP, and they are a distinct and separately identifiable service which can only be done safely by the SLP.

Discharge Evaluations

- Discharge evaluations are subject to a determination of medical necessity. They **may** be appropriate to report the health status of a patient to a referring health care practitioner or to establish a baseline health status upon discharge in complex cases where the patient has a history of recurrent episodes and/or has a complicated condition and has reached Maximum Therapeutic Benefit (MTB).

Evaluation and Re-Evaluation Services may be non-covered services (Per applicable client summaries)

For example:

- Evaluation of a well patient regardless of age for the purpose of maintenance, prevention or wellness
- Pre-participation sport physicals
- Pre-employment physicals

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