

Cigna Medical Coverage Policy- Therapy Services Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations

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INSTRUCTIONS FOR USE

Cigna / ASH Medical Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document may differ significantly from the standard benefit plans upon which these Cigna / ASH Medical Coverage Policies are based. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Cigna / ASH Medical Coverage Policy. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Determinations in each specific instance may require consideration of:

- 1) the terms of the applicable benefit plan document in effect on the date of service*
- 2) any applicable laws/regulations*
- 3) any relevant collateral source materials including Cigna-ASH Medical Coverage Policies and*
- 4) the specific facts of the particular situation*

Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant guidelines and criteria outlined in this policy, including covered diagnosis and/or procedure code(s) outlined in the Coding Information section of this policy. Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this policy. When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under this policy will be denied as not covered.

Cigna / ASH Medical Coverage Policies relate exclusively to the administration of health benefit plans.

Cigna / ASH Medical Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines.

Some information in these Coverage Policies may not apply to all benefit plans administered by Cigna. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make benefit determinations. References to standard benefit plan language and benefit determinations do not apply to those clients.

A variety of Current Procedural Terminology (CPT) codes represent examination/evaluation and established/re-evaluation/ patient services for rehabilitation providers. The choice of the appropriate code series is determined by practitioner licensure. The CPT codes for these services are found in these sections of this document:

- Physical Medicine and Rehabilitation section which includes codes for Physical Therapy, Occupational Therapy and Athletic Training Evaluations and Re-evaluations and Speech Language Pathologist (SLP) Services Evaluations and Re-evaluations
- Evaluation and Management (E/M) Services

Appropriate outcome measures (e.g., Oswestry Disability Index, Neck Disability Index, and Visual Analogue Pain Scale) are an integral part of these services. 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.

GUIDELINES

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:

- History
- Examination
- Clinical decision-making
- Development of a plan of care

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

- Occupational profile and client history (medical and therapy)
- Assessments of occupational performance
- Clinical decision making
- Development of plan of care

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

- History and physical activity profile
- Examination
- Clinical decision making
- 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.

CPT 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.

CPT Code	CPT Code Description
	Typically, 20 minutes are spent face-to-face with the patient and/or family.
97162	Physical therapy evaluation: moderate complexity, requiring these components: • A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; • An examination of body systems 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 of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; • An examination of body systems 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 (ie, 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 (eg, 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.
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 (ie, 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 (eg, 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 identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and

CPT Code	CPT Code Description
	Clinical decision making 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 (eg, 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.
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 policies *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) physical performance test or measurement, or assistive technology assessment codes (CPT 95851-95852, 97750, 97755) 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.

Reference for Physical Therapy Coding:

Body regions: Head, neck, back, lower extremities, upper extremities, and trunk.

Body systems: Musculoskeletal, neuromuscular, cardiovascular pulmonary, and integumentary.

A review of body systems includes the following:

- For the musculoskeletal system: the assessment of gross symmetry, gross range of motion, gross strength, height, and weight.
- For the neuromuscular system: a general assessment of gross coordinated movement (e.g., balance, gait, locomotion, transfers, and transitions) and motor function (motor control and motor learning).
- For the cardiovascular pulmonary system: the assessment of heart rate, respiratory rate, blood pressure, and edema.
- For the integumentary system: the assessment of pliability (texture), presence of scar formation, skin color, and skin integrity.

A review of any of the body systems also includes the assessment of the ability to make needs known, consciousness, orientation (person, place, and time), expected emotional/behavioral responses, and learning preferences (e.g., learning barriers, education needs).

Body structures: The structural or anatomical parts of the body, such as organs, limbs, and their components, classified according to body systems.

Coding Tip

When considering the *elements* included in the physical therapy evaluation, the number of body structures should be based on the degree or extent of the examination. For example, the examination may involve an entire limb, a joint, or a specific area of the spine. It is the therapist's responsibility to define and document the specific structure(s) examined.

Personal factors: Factors that include sex, age, coping styles, social background, education, profession, past and current experience, overall behavior pattern, character, and other factors that influence how disability is experienced by the individual. Personal factors that exist but do not affect the physical therapy plan of care should not be considered, when selecting a level of service.

Coding Tip

The physical therapy evaluation and re-evaluation codes are service-based codes. The typical time associated with the code descriptors are for guidance only and should not be used to determine the level of complexity.

Reference for Occupational Therapy Coding:

Occupational Profile

The occupational profile provides an understanding of the patient's occupational history and experiences, and patterns of daily living, interests, values, and needs. The patient's problems and concerns about performing occupational work (e.g. activities of daily living [ADLs]) are identified as part of the profile. The patient's presenting problem(s), the reason(s) for referral, and the patient's goal(s) are also determined.

Patient Medical and Therapy History

The patient's history, including both medical and therapy history, is reviewed to understand the presenting problem (e.g., recent fracture) and what is causing the patient to seek occupational therapy services. The amount and type of history (e.g. from the referring physician or qualified health care professional) reviewed depends on what the occupational therapist needs to know (e.g., postsurgical precautions, comorbidities) to continue with an assessment and development of a plan of care. To achieve expanded (moderate) or extensive (high) levels of profile and history, the therapist must also obtain and review the patient's physical, cognitive, or psychosocial history related to current functional performance.

Assessments of Occupational Performance

The second component that must be considered in determining the level of the evaluation service is related to both the assessment and identification of occupational performance deficits. Performance deficits are defined as activity limitations and/or participation restrictions that result from skills deficits. Performance deficits refer to the inability to complete activities due to the lack of skills in one or more of the categories below (i.e., relating to physical, cognitive, or psychosocial skills):

Physical skills: Physical skills refer to body structure or body function (e.g., balance, mobility, strength, endurance, fine or gross motor coordination, sensation, dexterity).

Cognitive skills: Cognitive skills refer to the ability to attend, perceive, think, understand, problem solve, mentally sequence, learn, and remember, resulting in the ability to organize occupational performance in a timely and safe manner. These skills are observed when a person (1) attends to and selects, interacts with, and uses task tools and materials; (2) carries out individual actions and steps; and (3) modifies performance when problems are encountered.

Psychosocial skills: Psychosocial skills refer to interpersonal interactions, habits, routines and behaviors, active use of coping strategies, and/or environmental adaptations to develop skills necessary to successfully and appropriately participate in everyday tasks and social situations.

Thus, "performance deficits" refer to activities or occupations, in which the client is experiencing functional problems with performance area, such as bathing, dressing, medication management, meal preparation, sleep routines, lifting, standing, or sitting for prolonged periods, that limits the client's activity level or ability to participate in daily life and occupation. Lack of skills or limitations in physical, cognitive, or psychosocial areas must be linked to the performance deficits that result in activity limitations and/or participation restrictions. The count of performance deficits is only one factor in assigning the level of code complexity, i.e., it is not the sole factor to determine the overall level. The complexity of the occupational profile and medical history and the complexity of the clinical reasoning, which results in the development of the plan of care, must also be considered.

Clinical Decision Making and Assessment

The extent of the assessment is a key factor in determining the level of the clinical decision making component. The language in the code descriptors focuses on analysis of data from problem-focused assessments for Low;

analysis of data from detailed assessments for Moderate; and analysis of data from comprehensive assessments for High.

Comorbidities

The type, number, and complexity of comorbidities that affect occupational performance or result in participation restrictions are important to code level selection. Evaluations of low complexity (97165) typically involve patients with no comorbidities, while evaluations of moderate (97166) or high (97167) complexity typically will have one or more comorbidities.

Number of Treatment Options

The number of treatment options is another factor in determining the level of clinical decision making. Using the information gathered throughout the evaluation, the occupational therapist may have to consider limited treatment options, several treatment options, or multiple treatment options. As a note, the clinical decision making required by the therapist to determine which treatment options to include and in what order to implement those options is of a higher complexity than when only limited treatment options are available.

Reference for Athletic Training Coding:

Body System Examination Includes:

Musculoskeletal system – The assessment of gross symmetry, gross range of motion, gross strength, height, and weight.

Neuromuscular system – A general assessment of gross coordinated movement (e.g., balance, gait, locomotion, transfers, and transitions) and motor function (motor control and motor learning).

Cardiovascular pulmonary system – The assessment of heart rate, respiratory rate, blood pressure, and edema.

Integumentary system – The assessment of pliability (texture), presence of scar formation, skin color, and skin integrity.

Examples (AMA CPT Assistant, CPG Changes, 2017):

Low complexity evaluation –

97161: A 45-year-old female presents with for a physical therapy evaluation 2 weeks after a grade 3 ankle sprain. She reports mild discomfort and stiffness in the ankle. She has no significant medical history and hopes to return to her job as a delivery person in 3 to 4 weeks. She ambulates with a cane for short distances on level surfaces and stairs.

97165: A 49-year-old female fell at home, sustaining a closed distal radius fracture to the right dominant wrist. At her return visit to the physician (6 weeks later), she continues to have limited active range of motion (ROM) and is referred to occupational therapy for range of motion and strengthening. The patient lives alone and is having difficulty with some activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

97169: A 42-year-old male presents with status post right second-degree inversion ankle sprain while participating in a recreational soccer league 5 days ago. Patient presents on crutches with touch-down weight-bearing, with mild to moderate effusion and ecchymosis with 2/10 pain at rest and 6/10 while ambulating.

Moderate complexity evaluation –

97162: A 74-year-old male presents for a physical therapy evaluation status post open reduction and internal fixation of his right fractured hip. He complains of moderate pain and swelling. The medical history includes a clotting disorder controlled by anticoagulant therapy. He has a 25-year smoking history. He is nonweight bearing on his right lower extremity and uses a rolling walker on level surfaces. He is unable to use stairs, squat, and drive and has difficulty getting in and out of cars and chairs.

97166: A 68-year-old male presents with a right below-knee amputation and generalized weakness. His past medical history includes degenerative joint disease, diabetes mellitus, depression, neuropathy, and diabetic retinopathy. He lives alone and has no structural home modifications (e.g. bathroom). He ambulates with a walker, without a lower extremity prosthesis. He is fearful of falling in the kitchen and bathroom, and his inability to return to driving makes accessing groceries and participating in a community activities a challenge.

97170: A 67-year-old retired female presents with a 4-week onset of right shoulder pain following her lifting her grandchild. Patient reports 2/10 pain at rest, 9/10 with shoulder movement, and cannot reach overhead. X rays were reportedly negative. Patient also reports a history of cigarette smoking, high blood pressure, and type-2 diabetes.

High complexity evaluation –

97163: A 58-year-old male presents for a physical therapy evaluation for problems that resulted from a fall 4 weeks ago. The patient fell and hit his head. He has memory loss related to the fall and, since the fall, has experienced weakness and paresthesia in the arm and hand and complains of tinnitus. He has limited his activity level to avoid falls and to compensate for the upper extremity weakness. His medical history includes poorly controlled diabetes, congestive heart failure, and hypertension. He has a sedentary lifestyle and poor compliance with medications. He reports dropping objects and has difficulty with dressing, performing personal hygiene, and doing light household chores.

97167: A 29-year-old male sustained a head injury while snowboarding but continued snowboarding until he lost consciousness. Medical evaluation shows a traumatic brain injury (TBI) with right-sided subdural hematoma. The patient's medical history includes multiple previous concussions while in high school. The patient is a computer technician, active in many sports, and was living independently in an apartment prior to the TBI 12 weeks ago. He presents with weakness and incoordination in the left upper extremity, impulsiveness, socially inappropriate behavior, short-term memory loss, balance impairment, and double vision that impacts driving, functional mobility, meal preparation, and reading.

97171: A 45-year-old iron worker, who experienced dizziness and fell from a height of 10 feet while working, suffering injuries that include a fractured left olecranon process and concussion. He did not lose consciousness; however, states recurrent mild headache with no dizziness, photophobia, or balance disturbance. He underwent an open reduction internal fixation (ORIF) of his olecranon with instructions to begin ROM and strengthening of his elbow, and gradual return to activity with respect to his concussion. Medical history includes hypertension, obesity, high cholesterol, and migraine headaches.

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

CPT Code	CPT Code Description
	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 reevaluation 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) or ROM or physical performance tests and measurement codes (95851-95852, 97750, 97755, respectively).

Examples (AMA CPT Assistant, CPG Changes, 2017):

97164: A 62-year-old male with low back pain presents for a physical therapy re-evaluation on his eighth visit of his episode of care. The patient had been making progress toward his goals. At his last visit, he reported a reduction in pain from 6/10 to 1/10 and an ability to return to driving and light exercise. However, at this visit, he presents with an increase in pain to 8/10 and describes radiation of pain and sensory loss in the right posterior leg and lateral foot. He is unable to sit for more than 3 minutes.

97168: A 66-year-old male with the diagnosis of left cerebrovascular accident, right hemiparesis, and mixed aphasia is referred for a reevaluation due to his improved functional mobility and a change to his living environment that requires new goals. He is living with his son and daughter-in-law and primarily uses a wheelchair for mobility. He has been seen for 12 outpatient occupational therapy visits that focused on increasing independence in self-care activities and functional mobility skills. He will be returning to this own home and would like to return to work as an accountant.

97172: A 45-year-old worker presents with 8 weeks status post-surgical repair of elbow and mild traumatic brain injury without loss of consciousness. Patient has been fully evaluated in the past, and has been cleared by his physician for increased activity and now presents for re-evaluation.

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 (eg, stuttering, cluttering)
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92610	Evaluation of oral and pharyngeal swallowing function

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 2017 Code: S9152 defines a Speech therapy, re-evaluation. This service 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.

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 Patient: 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

This CPG 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.

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:

- The total time for E/M services performed on the date of the encounter; or
- 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, the level of E/M code that was performed using the time guidelines will be evaluated 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 to 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, the level of E/M code that was performed will be re-evaluated 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 prolonged services 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 (not separately reported)
- The risk of complications, and/or morbidity, or mortality of patient management decisions made at the visit, associated with the diagnostic procedure(s), and treatment(s). This includes decisions 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 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 AMA 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 table is a comparison of all new patient and established patient Office or Other Outpatient E/M service CPT codes:

New Patient

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

Code	Medical Decision Making	History	Examination	Time
99211	N/A	NA	NA	N/A
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 in order 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.

Re-Evaluations (Use the appropriate Established Patient E/M series CPT 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, excluding Naturopathy and Podiatry, established patient E/M services, or re-evaluations, cannot be approved prospectively (service to be rendered in the future). If there is a future point at which the practitioner decides a re-evaluation is necessary based on a new problem or abnormality, a submission of those new examination findings is required. If a patient has a new injury or a significant exacerbation requiring an established patient E/M or re-evaluation service, it is appropriate to submit documentation of that event and the clinical findings obtained. In addition, an established patient E/M service without documentation of at least two of

three of the required elements of the E/M code (i.e., history, examination, level of complexity of medical decision making) cannot be approved.

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 is not reported on the date of office or other outpatient service when the highest level is reached (i.e., 99205, 99215).

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