

**Clinical Practice Guideline: Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations**

**Date of Implementation: January 31, 2008**

**Scope Specialty**

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Appropriate and timely assessment of the patient is fundamental to the efficient application of healthcare resources and to the promotion of quality patient outcomes. Information from initial assessments:

- Provides the basis for determining the working diagnosis;
- Reveals the possible occupational or social and/or psychosocial issues that may impact care;
- Identifies co-morbid or complicating factors; and
- Establishes the basis for an initial plan of care including:
  - Initial treatment trials;
  - Initial and subsequent functional outcome measures;
  - The need for additional diagnostic testing;
  - The need for referral to other healthcare practitioner(s) for evaluation, management, co-management, or coordination of care.

Appropriate and timely re-evaluations are necessary to:

- Refine the working diagnosis;
- Reevaluate possible impact of occupational, social and/or psychosocial issues that may impact care;
- Monitor patient response to the plan of care;
- Determine any necessary modifications to plan of care including:
  - The need for additional diagnostic testing;
  - Changes to treatment interventions;
  - Readiness for discharge from care;
  - New or further trauma or injury; and/or
  - The need for referral to other healthcare practitioner(s) for evaluation, management, co-management, or coordination of care.

A variety of Current Procedural Terminology (CPT) codes represent evaluation/reevaluation services. The choice of the appropriate evaluation/re-evaluation code series is determined by practitioner licensure. For specialties that use Evaluation and Management (E&M) codes, a New Patient is defined by CPT as one who has not received care from the practitioner or any other practitioner in the same practice within the same specialty in the previous three years. An Established Patient is defined by CPT for Physicians as a patient who has received prior care from the practitioner or another

1 practitioner in the practice of the same specialty in the previous three years. Practitioners  
 2 are encouraged to become familiar with the current CPT codes and their use as well as  
 3 with the applicable American Specialty Health – Specialty (ASH) client summaries.

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 5 Appropriate outcome measures (e.g., Oswestry Disability Index, Neck Disability Index,  
 6 and Visual Analogue Pain Scale) are an integral part of every assessment. These tools  
 7 allow the practitioner to quantify the patient’s clinical and/or functional status, identify  
 8 prognostic indicators, measure changes in clinical and/or functional status over time, and  
 9 assess the effectiveness of interventions, thereby significantly improving clinical  
 10 performance. Please see [ashcompanies.com](http://ashcompanies.com) or [ashlink.com](http://ashlink.com) for additional information on  
 11 various outcome assessment tools and other ASH Clinical Practice Guidelines.

### 12 13 **Medical Necessity Criteria for Initial Evaluations**

14 An initial evaluation of a patient presenting for healthcare services is always considered  
 15 medically necessary in order to:

- 16 • Provide the basis for determining the working diagnosis;
- 17 • Reveal the possible occupational, social and/or psycho-social issues that may  
 18 impact care;
- 19 • Identify co-morbid or complicating factors; and
- 20 • Establish the basis for an initial plan of care including:
  - 21 ○ The need for additional diagnostic testing; and
  - 22 ○ The need for referral to other healthcare practitioner(s) for evaluation,  
 23 management, co-management or coordination of care.

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 25 In addition, an initial assessment for a new condition by a Physical Therapist or  
 26 Occupational Therapist is defined as the evaluation of a patient:

- 27 • For which this is their first encounter with the practitioner or practitioner group;
- 28 • Who presents with:
  - 29 ○ A new injury or new condition; or
  - 30 ○ The same or similar complaint after discharge from previous care.

### 31 32 **Medical Necessity Criteria for Re-Evaluations**

33 A re-evaluation of a patient currently undergoing a course of care from a practitioner is  
 34 considered medically necessary to:

- 35 • Establish refinement of the working diagnosis;
- 36 • Re-evaluate possible impact of occupational, social and/or psycho-social issues  
 37 that may impact care;
- 38 • Monitor patient response following a reasonable trial of care;
- 39 • Determine any necessary modifications to the plan of care including:
  - 40 ○ The need for additional diagnostic testing;
  - 41 ○ Changes to treatment interventions or continuance/continuing care;
  - 42 ○ Readiness for discharge from care;

- New or further trauma or injury; and/or
- The need for referral to other healthcare practitioner(s) for evaluation, management, co-management, or coordination of care.

A re-evaluation for continuing care by a Physical Therapist or Occupational Therapist is defined as a re-examination of a patient:

- For which patient is currently undergoing a course of care over a reasonable amount of time,
- An exacerbation or significant change in patient/client status or condition
- Determined medically necessary when updated clinical findings submitted support medical necessity of continued skilled intervention as mentioned above.

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 to determine whether continuing care is appropriate, 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, ASH cannot approve 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).

### **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 cases where the patient has a history of recurrent episodes and/or has a complicated condition and has reached Maximum Therapeutic Benefit (MTB).

### **Non-Covered Evaluation and Re-Evaluation Services:**

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

### **References**

American Medical Association. (2009). *Current procedural terminology (CPT) 2012*. Chicago, IL: AMA.

American Physical Therapy Association. (2003). *Guide to physical therapy practice* (Revised 2<sup>nd</sup> ed). Alexandria, VA: APTA.

- 1 Haldeman, S., Chapman-Smith, D., & Petersen, D. M. (1993). *Guidelines for*
- 2 *chiropractic quality assurance and practice parameters*. Gaithersburg, MD: Aspen
- 3 Publishers.
- 4
- 5 Ingenix coding book (2012). *Coding and payment guide for the physical therapist*. Salt
- 6 Lake City, UT: St. Anthony Publishing.