

# Local Coverage Article: Billing and Coding: Therapy Evaluation Coding (A55371)

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## Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	01111 - MAC A	01111 - MAC A	J - E	California - Entire State
Noridian Healthcare Solutions, LLC	01112 - MAC B	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	01182 - MAC B	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	01211 - MAC A	01211 - MAC A	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	01212 - MAC B	01212 - MAC B	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	01311 - MAC A	01311 - MAC A	J - E	Nevada
Noridian Healthcare Solutions, LLC	01312 - MAC B	01312 - MAC B	J - E	Nevada
Noridian Healthcare Solutions, LLC	01911 - MAC A	01911 - MAC A	J - E	American Samoa California - Entire State Guam Hawaii

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
				Nevada Northern Mariana Islands

# Article Information

## General Information

**Article ID**

A55371

**Original Effective Date**

01/01/2017

**Article Title**

Billing and Coding: Therapy Evaluation Coding

**Revision Effective Date**

N/A

**Article Type**

Billing and Coding

**Revision Ending Date**

N/A

**AMA CPT / ADA CDT / AHA NUBC Copyright Statement**

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**Retirement Date**

N/A

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## CMS National Coverage Policy

N/A

### Article Guidance

#### Article Text:

Noridian Healthcare Solutions, LLC is posting this article to assist providers in determining appropriate coding for therapy evaluation services.

Providers occasionally receive multiple physician orders for multiple conditions for the same patient. Because of the multiple conditions and specialization of therapists, this often results in the patient being evaluated by multiple therapists of the same discipline. The Centers for Medicare and Medicaid Services (CMS) does not require therapists to complete separate evaluations and plans of care for the treatment of patients with multiple medical conditions. The licensed clinician is expected to complete a thorough initial patient evaluation, which would include an assessment for each of the medical conditions requiring therapy treatment. Multiple evaluations occurring during a single episode of care (within a single therapy discipline) are not separately reimbursable except in the rare circumstance described below. However, CMS does not restrict the number of therapists (within a single therapy discipline) that can treat a patient. Providers may choose to have one or more on-staff therapists that specialize in the treatment of specific medical conditions (specialty therapists) work with the patient to optimize their full rehabilitation potential.

#### Coding Considerations

A patient is being treated at the outpatient therapy clinic for condition A. During the course of treatment for condition A, the patient comes to the clinic for treatment of a new diagnosis, condition B:

Scenario 1: When condition B is related to condition A, then the appropriate code to bill for the evaluation service provided is a re-evaluation using CPT code 97164 - Re-evaluation of physical therapy established plan of care. Typically, *20 minutes* are spent face-to-face with the patient and/or family or 97168 - Reevaluation of occupational therapy established plan of care. Typically, *30 minutes* are spent face-to-face with the patient and/or family for Occupational Therapists.

Example: A patient is receiving treatment for a total knee arthroplasty (TKA). During the episode of care, the patient develops shoulder pain. The clinician determines the pain is due to use of a walker, which the patient is using as a result of the TKA. In this scenario, the shoulder pain is a condition related to the TKA. Therefore, it is appropriate for the clinician to provide a re-evaluation of the patient due to this related condition.

Scenario 2: When condition B is not related, directly or indirectly, to condition A, then the evaluation of condition B would warrant billing for a new evaluation using CPT codes 97161 - Physical therapy evaluation: low complexity.

Typically, *20 minutes* are spent face-to-face with the patient and/or family, 97162 - Physical therapy evaluation: moderate complexity. Typically, *30 minutes* are spent face-to-face with the patient and/or family or 97163 - Physical therapy evaluation: high complexity. Typically, *45 minutes* are spent face-to-face with the patient and/or family for Physical Therapy or 97165 - Occupational therapy evaluation, low complexity. Typically, *30 minutes* are spent face-to-face with the patient and/or family, 97166 - Occupational therapy evaluation, moderate complexity. Typically, *45 minutes* are spent face-to-face with the patient and/or family or 97167 - Occupational therapy evaluation, high complexity. Typically, *60 minutes* are spent face-to-face with the patient and/or family for Occupational Therapists.

Example: A patient is receiving treatment following a TKA. During the episode of care for the TKA, the patient develops an acute rotator cuff injury from an accident at home. The clinician determines the rotator cuff injury is not related to the TKA. Therefore, it is appropriate for the clinician to provide a new evaluation for the rotator cuff injury since it a newly identified diagnosis for an unrelated condition.

In either case, it is necessary for the documentation to accurately support the services provided.

**Source:**

**Medicare Benefit Policy Manual** ([MBPM](#)) Chapter 15 section 220(A) and 220.3.5(A)

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## Coding Information

**CPT/HCPCS Codes**

N/A

**CPT/HCPCS Modifiers**

N/A

**ICD-10 Codes that Support Medical Necessity**

N/A

**ICD-10 Codes that DO NOT Support Medical Necessity**

N/A

**Additional ICD-10 Information**

N/A

**Bill Type Codes:**

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

**Revenue Codes:**

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

**Other Coding Information**

N/A

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**Revision History Information**

N/A

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**Associated Documents****Related Local Coverage Document(s)**

N/A

**Related National Coverage Document(s)**

N/A

**Statutory Requirements URL(s)**

N/A

**Rules and Regulations URL(s)**

N/A

**CMS Manual Explanations URL(s)**

N/A

**Other URL(s)**

N/A

**Public Version(s)**

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- Initial evaluation
- Re-evaluation
- eval

- therapy
- PT
- OT
- 97161
- 97162
- 97163
- 97164
- 97165
- 97166
- 97167
- 97168