Local Coverage Article:
Billing and Coding: Therapy Evaluation, Re-Evaluation and Formal Testing (A53309)

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Contractor Information

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

Article Information

General Information

Article ID
A53309

Article Title
Billing and Coding: Therapy Evaluation, Re-Evaluation and Formal Testing

Article Type
Billing and Coding

Original Effective Date
10/01/2015

Revision Effective Date
01/01/2020

Revision Ending Date
N/A

Retirement Date
N/A

CMS National Coverage Policy

N/A

Article Guidance

Article Text:

Therapy evaluation and formal testing services involve clinical judgment and decision-making which is not within the scope of practice for therapy assistants. These services can only be provided by qualified clinicians i.e., a physician, non-physician practitioner (NPP), therapist or speech-language pathologist (SLP).

Therapy evaluation, re-evaluation, and formal testing codes can only be billed when the medical record supports the completion of a medically necessary comprehensive evaluation or formal test. Documentation must support that the service was needed based on the patient's current clinical status or condition. Medicare does not reimburse for services related solely to workplace skills and activities. Additional evaluative services may be necessary when an episode of care is interrupted by a short-stay inpatient hospitalization or outpatient surgery that could reasonably impact the patient's therapy progression. Note that routine continuous assessment of the patient's expected progress in accordance with the plan of care is not separately reimbursable as a re-evaluation or formal testing service.

Initial Evaluations - (i.e., CPT ® 97161-97163,97165-97167)
Providers may simultaneously receive multiple physician referrals for multiple medical conditions for one patient. When this occurs, it is expected that one qualified clinician from each appropriate discipline i.e., physical therapist (PT), and/or occupational therapist (OT), and/or SLP, will complete a thorough initial evaluation that encompasses each of the identified medical conditions. Following completion of the initial evaluation, other staff therapists specializing in specific medical conditions may treat the patient as needed. When medical necessity is supported, an initial evaluation is appropriate for:

• A new patient who has not received prior therapy services.
• A patient who has returned for additional therapy after having been discharged from prior therapy services for the same or for a different condition. Time spent evaluating this returning patient should not be coded as a re-evaluation. Prior discharge may have been due to one of the following:

- Patient no longer significantly benefited from ongoing therapy services or;
- Patient no longer required therapy services for an extended period of time or;
- Patient experienced a significant change in medical status that necessitated discharge.

• A patient who is currently receiving therapy services and develops a newly diagnosed unrelated condition. Example: A patient is currently receiving treatment following a total knee arthroplasty (TKA). During the therapy episode of care for the TKA, the patient develops an acute rotator cuff injury from an accident at home. The clinician determines that the rotator cuff injury is not related to the TKA. Therefore, it is reasonable for the clinician to provide and code for a new evaluation of the rotator cuff injury since it is a newly identified diagnosis for an unrelated condition.

For additional information, see the attached *"Medical Necessity of Therapy Services"* article in the Related Coverage Documents link below.

Re-Evaluations- (i.e., CPT®97164, 97168)
Re-evaluations are separately reimbursable when the medical record supports that the patient's clinical status or condition required the additional evaluative service. When medical necessity is supported, a re-evaluation is appropriate and is separately billable for:

• A patient who is currently receiving therapy services and develops a newly diagnosed related condition e.g., a patient that is currently receiving therapy treatment for TKA. During the episode of care, the patient develops wrist

pain. The clinician determines that the wrist pain is due to use of a walker which the patient is using as a result of the TKA. In this scenario, the wrist pain is a condition that is related to the TKA. Therefore, it is reasonable for the clinician to provide a re-evaluation of the patient due to this related condition.
• A patient who is currently receiving therapy services and demonstrates a significant improvement, decline, or change in condition or functional status which was not anticipated in the plan of care and necessitates additional evaluative services to maximize the patient's rehabilitation potential.

Note that routine continuous assessment of the patient's expected progress in accordance with the plan of care is not considered to be a medically necessary service and is not separately reimbursable as a re-evaluation. Limited routine assessment (e.g., for progress reporting) is a component of ongoing therapy services an is included in services and procedures.

Formal Testing (i.e., CPT®97750, 95851-95852)
Formal testing services are considered inclusive (not separately reimbursable) when they are provided on the same day as an initial evaluation or re-evaluation service. Formal testing services are separately reimbursable when the medical record supports that the patient's clinical status or condition required the additional testing service. Formal testing services should not be billed using therapy service or procedure codes. When medical necessity is supported a formal test is appropriate and is separately reimbursable when documentation supports the completion of a formal, date signed, distinctly identifiable findings report which includes:

• Testing and/or measurement results with comparative values for specific standardized grading scales.
• Provider's interpretation of results.
• Support of how the findings were incorporated into the therapy plan of care, when applicable.

Note that routine continuous assessment of the patient's expected progress in accordance with the plan of care is not considered to be a medically necessary service and is not separately reimbursable as a formal test. Limited routine assessment (e.g., for progress reporting) is a component of ongoing therapy services and is included in services and procedures.

Sources:
• *Current Procedural Terminology (CPT) Manual*
• CMS Internet Only Manual (IOM), Medicare Benefit Policy Manual, Publication 100-02, Chapter 15, Sections 220(A), 220.3.5(A), 230.1.
• IOM, Medicare Benefit Policy Manual,, Publication 100-02, Chapter 16, Section 150

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes:

CODE	DESCRIPTION
95851	RANGE OF MOTION MEASUREMENTS AND REPORT (SEPARATE PROCEDURE); EACH EXTREMITY (EXCLUDING HAND) OR EACH TRUNK SECTION (SPINE)

CODE	DESCRIPTION
95852	RANGE OF MOTION MEASUREMENTS AND REPORT (SEPARATE PROCEDURE); HAND, WITH OR WITHOUT COMPARISON WITH NORMAL SIDE
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.
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 IN 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.
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.
97165	OCCUPATIONAL THERAPY EVALUATION, LOW COMPLEXITY, REQUIRING THESE COMPONENTS: AN OCCUPATIONAL PROFILE AND MEDICAL AND THERAPY HISTORY,

CODE	DESCRIPTION
	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 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

CODE	DESCRIPTION
	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.
97750	PHYSICAL PERFORMANCE TEST OR MEASUREMENT (EG, MUSCULOSKELETAL, FUNCTIONAL CAPACITY), WITH WRITTEN REPORT, EACH 15 MINUTES

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 policy, 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 policy should be assumed to apply equally to all Revenue Codes.

N/A

Other Coding Information

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
01/01/2020	R4	This article was updated to change the title of the article from Therapy Evaluation and Assessment Services to Therapy Evaluation, Re-Evaluation and Formal Testing, and verbiage was updated. The following CPT codes were removed from Group 1: 95831, 95832, 95833, 95834
01/01/2017	R3	Article converted to Billing and Coding. No change is coverage was made.
01/01/2017	R2	Corrected links to Benefit Policy Manual and Claims Processing Manual
01/01/2017	R1	This article is revised to change the initial PT/OT evaluation codes to 97162-97163 for PT and 97165-97167 for OT and Reevaluation codes 97164 & 97168 and deleted CPT® codes 97001, 97002, 97003 & 97004 effective 01/01/2017. Also, this article now combines JEA A53308 into the JEB article A53309 so that both JEA and JEB contract numbers will have the same final MCD article number as JEB A53309.

Associated Documents

Related Local Coverage Document(s)

Article(s)
A53304 - Billing and Coding: Medical Necessity of Therapy Services
A53339 - Billing and Coding: Therapy Students and Aides

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

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