

Local Coverage Article: Therapy Evaluation and Assessment Services (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 American Samoa
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	Guam Hawaii Northern Mariana Islands American Samoa
Noridian Healthcare Solutions, LLC	A and B MAC	01212 - MAC B	J - E	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 American Samoa California - Entire State
Noridian Healthcare Solutions, LLC	A and B MAC	01911 - MAC A	J - E	Guam Hawaii Nevada Northern Mariana Islands

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Article Information

General Information

Article ID A53309	Original Article Effective Date 10/01/2015
Article Title Therapy Evaluation and Assessment Services	Revision Effective Date 01/01/2017
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	Retirement Date N/A

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Article Guidance

Article Text:

Therapy evaluation and assessment 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 and re-evaluation codes can only be billed when the medical record supports a completed comprehensive evaluation. Documentation must support that the evaluative service was medically necessary based on the patient's current status and medical/functional history. 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. Treatment codes should not be submitted for time spent providing evaluative services.

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)

Routine re-evaluations of expected progression in accordance with the plan of care, either during the episode of care or upon discharge, are not considered to be medically necessary separately billable services. When medical necessity is supported, a re-evaluation is appropriate 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.

Additional Assessments (i.e., CPT ® 97750, 95831-95834, 95851-95852)

Assessment services are considered inclusive (not separately reimbursable) when they are provided on the same day as an initial evaluation or re-evaluation service. Routine assessments of expected progression in accordance with the plan of care, either during the episode of care or upon discharge, are not considered to be medically necessary separately billable services. Therapy assessment codes should only be billed when the medical record supports that formal tests and measurements were completed and that these additional non-routine assessment services were medically necessary based on the patient's current status and medical/functional history. Assessment services should not be billed using therapy treatment codes. Documentation must include 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.

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 [Back to Top](#)
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Coding Information

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 article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article 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

CPT/HCPCS Codes

Group 1 Paragraph:

95831
95832
95833

95834
95851
95852
97161
97162
97163
97164
97165
97166
97167
97168
97750

Group 1 Codes: N/A

Group 1 CPT/HCPCS Code Group 1 CPT/HCPCS Code Description

ICD-10 Codes that are Covered N/A

ICD-10 Codes that are Not Covered N/A

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[Revision History Information](#)

Revision History Date	Revision History Number	Revision History Explanation
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.

[Back to Top](#) **Related Local Coverage Document(s)** Article(s) [A53304 - Medical Necessity of Therapy Services](#)
[A53339 - 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

Public Version(s) Updated on 01/06/2017 with effective dates 01/01/2017 - N/A [Updated on 12/21/2016 with effective dates 01/01/2017 - N/A](#) [Updated on 07/10/2014 with effective dates 10/01/2015 - N/A](#) [Back to Top](#)

[Keywords](#)

- PT
- OT
- Evaluation
- Re-evaluation
- 97161
- 97162
- 97163
- 97164
- 97165
- 97166

- 97167
- 97168
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