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

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
- 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.
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 new evaluation codes reflect 3 levels of patient presentation: low-complexity, moderate-complexity, and high-complexity, and replace the current PT, OT and AT evaluation codes. Four components are used to select the appropriate PT evaluation CPT code. These include: 1. Patient history and comorbidities; 2. Examination and the use of standardized tests and measures; 3. Clinical presentation; 4. Clinical decision making. Four components are used to select the appropriate OT evaluation CPT code. These include: 1. Occupational profile and client history (medical and therapy); 2. Assessments of occupational performance; 3. Clinical decision making; 4. Development of plan of care. Four components are used to select the appropriate AT evaluation CPT code. These include: 1. History and physical activity profile; 2. Examination; 3. Clinical decision making; 4. 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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Code Description</th>
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| 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 with 1-2 personal factors and/or comorbidities that impact the plan of care;  
  - An examination of body system(s) 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. |
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>97163</td>
<td><strong>Physical therapy evaluation, high complexity, requiring these components:</strong> ● A history with 3 or more personal factors and/or comorbidities that impact the plan of care; ● An examination of body system(s) 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.</td>
</tr>
<tr>
<td>97165</td>
<td><strong>Occupational therapy evaluation, low complexity, requiring these components:</strong> ● 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 (i.e., 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 (e.g., 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.</td>
</tr>
<tr>
<td>97166</td>
<td><strong>Occupational therapy evaluation, moderate complexity, requiring these components:</strong> ● 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 (i.e., 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 (e.g., 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.</td>
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<tr>
<td>97167</td>
<td><strong>Occupational therapy evaluation, high complexity, requiring these components:</strong> ● 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 identify 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and ● A clinical decision-making is 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 (e.g., 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.</td>
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<td>97169</td>
<td>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.</td>
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<tr>
<td>97170</td>
<td>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.</td>
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<tr>
<td>97171</td>
<td>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.</td>
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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

Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations (CPG 111)
• 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 test and measurement, range of motion (ROM) or manual muscle testing (MMT) codes (CPT 95831-95834, 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:
  o For the musculoskeletal system: the assessment of gross symmetry, gross range of motion, gross strength, height, and weight.
  o For the neuromuscular system: a general assessment of gross coordinated movement (eg, balance, gait, locomotion, transfers, and transitions) and motor function (motor control and motor learning).
  o For the cardiovascular pulmonary system: the assessment of heart rate, respiratory rate, blood pressure, and edema.
  o 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 (eg, 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.

Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations (CPG 111)
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

Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations (CPG 111)
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 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 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.

Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations (CPG 111)
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

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<tr>
<td>97164</td>
<td>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</td>
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| 97168    | Re-evaluation of occupational therapy established plan of care, requiring these components: ● An assessment of changes in patient functional or medical

Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations (CPG 111)
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 re-evaluation 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).


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 test and measurement, ROM, MMT codes (95831-95834, 95851-95852, 97750, 97755).

**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 his 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)

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<th>CPT Code</th>
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<tr>
<td>92521</td>
<td>Evaluation of speech fluency (eg, stuttering, cluttering)</td>
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<tr>
<td>92522</td>
<td>Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)</td>
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<tr>
<td>92523</td>
<td>Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)</td>
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<tr>
<td>92524</td>
<td>Behavioral and qualitative analysis of voice and resonance</td>
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<tr>
<td>92525</td>
<td>Treatment of swallowing dysfunction and/or oral function for feeding</td>
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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) 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 (including 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, Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations (CPG 111)
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.

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**Evaluation and Management (E/M) Coding Overview:**

For specialties that use E/M codes, a New Patient is defined by the CPT manual 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 manual 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 manual, E/M codes refer to Evaluation and Management services provided during the physician/qualified health care professional-patient face-to-face interaction. The typically used E/M codes are Office or Other Outpatient Services for New Patients: 99201 - 99205 and for Established Patient: 99211 – 99215. Proper E/M coding is a requirement under the federal Health Insurance Portability and Accountability Act (HIPAA).

Evaluation and Management coding is based on seven (7) components:

1. Three (3) key components *(E/M coding is based on the level of service provided in each of these key components during each office visit.)*
   - Patient History
   - Examination

Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations (CPG 111)
Medical decision making

2. Three (3) Contributory Components
   - Counseling
   - Coordination of Care
   - Nature of presenting problem

3. One (1) Other Component
   - Time

The extent of the patient history is dependent upon the nature of the presenting problems and clinical judgment. There are four types of history that are defined: problem focused, expanded problem focused, detailed, and comprehensive.

1. Problem focused: Chief complaint; brief history of present illness or problem.
2. Expanded problem focused: Chief complaint; brief history of present illness; problem pertinent review.
3. Detailed: Chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family, and social history directly related to the patients problems.
4. Comprehensive: Chief complaint; extended history of present illness; review of systems which is directly related to the problems identifies in the history of present illness plus a review of systems of all additional body systems; complete past, family and social history.

The extent of the examination performed is also dependent on the nature of the problem and clinical decision making. There are four types of examinations that are defined; problem focused, expanded problem focused, detailed, and comprehensive.

1. Problem focused exam: A limited examination of the affected body area or organ system.
2. Expanded problem focused: A limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
3. Detailed: An extended examination of the affected body areas and other symptomatic or related organ system(s).
4. Comprehensive: A general multi-system examination or a complete examination of a single organ system.

Medical decision making is an essential part and refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

1. The number of possible diagnoses and the number of management options
2. The amount or complexity of medical records, diagnostic tests and other information
3. The risk of serious complications, morbidity and mortality as well as comorbidities.

There are four recognized types of medical decision making: straightforward, low complexity, moderate complexity, and high complexity.

It should be remembered that Medical Necessity for the level of service chosen must be demonstrated. The actual performance of a comprehensive level of service does not justify the billing of a comprehensive service if the presenting complaint could have been managed adequately with a detailed or lower level of service. It should also be remembered that it is the unusual case that presents with a condition that meets or exceeds moderate medical decision-making. In fact, typical cases, by their very nature as “typical,” generally meet only straightforward clinical decision-making criteria.

After gathering all this information, the practitioner can select the appropriate level of E/M service based on the following:

1. The practitioner must meet or exceed three (3) out of three (3) key components for new patient 99201 – 99205 CPT codes
2. The practitioner must meet or exceed two (2) out of three (3) key components for established patient 99211 – 99215 CPT codes
3. Time override option: When counseling and coordination of care take more than 50% of the practitioner’s face to face time with the patient and/or family, then time shall be the key factor in reporting/billing the
level of E/M service. The time approximation must meet or exceed the level of E/M service reported/billed and should not be rounded to the next higher level.

It must be appropriately and sufficiently documented in the medical record that the practitioner personally furnished the direct face-to-face time with the patient. Make sure that the start and end times of the visit are documented, along with the date of service.

The following table is a comparison of all new patient and established patient office service CPT codes:

### New Patient

<table>
<thead>
<tr>
<th>Code</th>
<th>Presenting Problem</th>
<th>History</th>
<th>Examination</th>
<th>Clinical Decision-Making</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Self-limited or Minor</td>
<td>Problem-Focused</td>
<td>Problem-Focused</td>
<td>Straightforward</td>
<td>10 minutes</td>
</tr>
<tr>
<td>99202</td>
<td>Low to Moderate</td>
<td>Expanded Problem-Focused</td>
<td>Expanded Problem-Focused</td>
<td>Straightforward</td>
<td>20 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>Moderate</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low</td>
<td>30 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>Moderate to High</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate</td>
<td>45 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>Moderate to High</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
<td>60 minutes</td>
</tr>
</tbody>
</table>

### Established Patient

<table>
<thead>
<tr>
<th>Code</th>
<th>Presenting Problem</th>
<th>History</th>
<th>Examination</th>
<th>Clinical Decision-Making</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Minimal</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>5 minutes</td>
</tr>
<tr>
<td>99212</td>
<td>Self-limited or Minor</td>
<td>Problem-Focused</td>
<td>Problem-Focused</td>
<td>Straightforward</td>
<td>10 minutes</td>
</tr>
<tr>
<td>99213</td>
<td>Low to Moderate</td>
<td>Expanded Problem-Focused</td>
<td>Expanded Problem Focused</td>
<td>Low</td>
<td>15 minutes</td>
</tr>
<tr>
<td>99214</td>
<td>Moderate to High</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Moderate</td>
<td>25 minutes</td>
</tr>
<tr>
<td>99215</td>
<td>Moderate to High</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
<td>40 minutes</td>
</tr>
</tbody>
</table>

### 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.

**Examples (AMA CPT, current year)**

99201 – Initial office visit for the evaluation and management of a contusion of a finger.
99202 – Initial office visit for a 25-year-old patient with single season allergic rhinitis.

99203 –
Initial office visit for a 30-year-old female with pain in the lateral aspect of the forearm.

Initial office visit for a 53-year-old laborer with degenerative joint disease of the knee with no prior treatment.

Initial office visit for a 14-year-old male with unilateral anterior knee pain.

99204 – Initial office visit for a 13-year-old female with progressive scoliosis.

99205 –
Initial office visit for a 75-year-old female with neck and bilateral shoulder pain, brisk deep tendon reflexes, and stress incontinence.

Initial office visit for a 60-year-old male with previous back surgery; now presents with back and pelvic pain, two-month history of bilateral progressive calf and thigh tightness and weakness when walking, causing several falls.

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, 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).

Examples (AMA CPT, current year)

99211 – Office visit for a 45-year-old female, established patient, for a blood pressure check.

99212 –
Office visit for a 50-year-old male, established patient, recently seen for acute neck pain, diagnosis of spondylosis, responding to physical therapy and intermittent cervical traction. Returns for evaluation for return to work.

Evaluation for a 50-year-old male, established patient, who has experienced a recurrence of knee pain after he discontinued NSAID.

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Office visit with a 65-year-old female, established patient, returns for three-week follow-up for resolving severe ankle sprain.

99213 – Office visit for a 45-year-old female, established patient, with known osteoarthritis and painful swollen knees.

99214 – Office visit for a 30-year-old, established patient, under management for intractable low back pain, who now presents with new onset right posterior thigh pain.

Office visit for an established patient with frequent intermittent, moderate to severe headaches requiring beta blocker or tricyclic antidepressant prophylaxis, as well as four symptomatic treatments, but who is still experiencing headaches at a frequency of several times a month that are unresponsive to treatment.

Office visit for a 55-year-old male, established patient, with increasing night pain, limp, and progressive varus of both knees.

99215 – Office visit for an established patient having acute migraine with new onset neurological symptoms and whose headaches are unresponsive to previous attempts at management with a combination of preventive and abortive medication.

**Evaluation Management for Consultations & Management**

**Office Consultations Overview:**
An office consultation is a type of E/M service provided at the request of another physician or appropriate source to either: 1) recommend care for a specific condition or problem; or 2) to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem. There is one set of codes for this service for new or established patients.

The practitioner must meet or exceed the three (3) out of three (3) key components of history, examination, and medical decision making for the office consultation 99241-99245 codes. Counseling and/or coordination of care with other practitioners or agencies should be provided consistent with the nature of the patient's problem(s) and the patient's and/or the patient's family's needs. This service requires the practitioner to have direct (face-to-face) contact with the patient and/or the patient's family.

The following information must be clearly documented in the patient's medical record: 1) request for a consultation from an appropriate source [e.g. referral letter]; 2) the reason[s] why a consultation is needed; 3) provision for a practitioner whose advice, opinion, recommendation, suggestion, direction, or counsel, etc., is requested for evaluating and/or treating a patient since that individual's expertise in a specific medical area is beyond the scope of knowledge of the requesting practitioner; 4) a written report of findings and recommendations from the consultant to the referring practitioner.

This service may **not** be used for: 1) another appropriately requested and documented consultation pertaining to the same or a new problem; 2) the repeat use of consultation codes; 3) any distinctly recognizable procedure or service provided on or following the consultation; 4) assumption of care (all or partial); 5) consultation prompted by the patient and/or the patient's family.

The following is a table of the new patient and established patient office consultation codes:

**New and Established Patients**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Presenting Problem</th>
<th>History</th>
<th>Examination</th>
<th>Clinical Decision-Making</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241</td>
<td>Self-limited or Minor</td>
<td>Problem-Focused</td>
<td>Problem-Focused</td>
<td>Straightforward</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>

Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations (CPG 111)
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Level of Evaluation</th>
<th>Time (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99242</td>
<td>Low to Moderate</td>
<td>30</td>
</tr>
<tr>
<td>99243</td>
<td>Moderate</td>
<td>40</td>
</tr>
<tr>
<td>99244</td>
<td>Moderate to High</td>
<td>60</td>
</tr>
<tr>
<td>99245</td>
<td>Moderate to High</td>
<td>80</td>
</tr>
</tbody>
</table>

**Examples (AMA CPT, current year)**

99241 – Initial office consultation for a 62-year-old construction worker with olecranon bursitis.

Office consultation for 30-year-old female tennis player with sprain or contusion of the forearm.

99242 – Office consultation with 66-year-old female with wrist and hand pain, and finger numbness, secondary to suspected carpal tunnel syndrome.

Initial office consultation for a 29-year-old soccer player with painful proximal thigh/groin injury.

99243 – Office consultation for a 65-year-old man with chronic low-back pain radiating to the leg.

Initial office consultation for a 60-year-old male with avascular necrosis of the left femoral head with increasing pain.

99244 – Initial office consultation for a 36-year-old factory worker, status four months post-occupational low back injury and requires management of intractable low back pain.

Initial office consultation for a 45-year-old female with a history of chronic arthralgia of TMJ and associated myalgia and sudden progressive symptomatology over last two to three months.

99245 – Initial office consultation for a 36-year-old patient, one year status post occupational herniated cervical disk treated by laminectomy, requiring management of multiple sites of intractable pain, depression, and narcotic dependence.

Office consultation for independent medical evaluation of a patient with a history of complicated low back and neck problems with previous multiple failed back surgeries.

**Prolonged Services Coding Overview:**

CPT Codes 99354 and 99355 are used when a physician/qualified health care professional provides prolonged services involving direct (face to face) patient contact that is beyond the usual service in the outpatient setting. The time for usual service refers to the typical/average time units associated with each level of E/M service. This service is reported in addition to other practitioner services, including E/M services at any level. Codes 99354 and 99355 are used to report the total duration of face to face time spent by a practitioner on a given date providing prolonged services, even if the time spent by the practitioner on that date is not continuous.

**CPT Code 99354** is used to report the first hour of prolonged services on a given date. This code may be used to report a total duration of prolonged services (add-on) of 30 – 60 minutes on a given date. 99354 must be used in conjunction with code 99203 – 99205, or 99213 – 99215. Prolonged services of less than thirty (30) minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management code.

**CPT Code 99355** is used to report each additional thirty (30) minutes beyond the first hour (in addition to 99354). 99355 may be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of
less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately. 99355 may only be used in conjunction with code 99354. Code 99355 may be multiplied.

Example for CPT codes 99354 and 99355 – A 20-year-old female with history of asthma presents with acute bronchospasm and moderate respiratory distress. Initial evaluation shows respiratory rate 30, labored breathing and wheezing heard in all lung fields. Office treatment is initiated which includes intermittent bronchial dilation and subcutaneous epinephrine. Requires intermittent physician face-to-face time with patient over a period of two-three hours.

The following examples illustrate the correct reporting of prolonged services with direct patient contact in the office setting:

<table>
<thead>
<tr>
<th>Total Duration of Prolonged Services</th>
<th>CPT Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;less than 30 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>30 – 74 minutes (1/2 hour – 1 hr 14 min)</td>
<td>E/M code + 99354 x 1</td>
</tr>
<tr>
<td>75 – 104 minutes (1 hr 15 min – 1 hr 44 min)</td>
<td>E/M code + 99354 x 1 and 99355 x 1</td>
</tr>
<tr>
<td>105 – 134 minutes (1 hr 45 min – 2 hr 14 min)</td>
<td>E/M code + 99354 x 1 and 99355 x 2</td>
</tr>
<tr>
<td>135- 164 minutes (2 hr 15 min – 2 hr 44 min)</td>
<td>E/M code + 99354 x 1 and 99355 x 3</td>
</tr>
<tr>
<td>165 – 194 minutes (2 hr 45 min – 3 hr 14 min)</td>
<td>E/M code + 99354 x 1 and 99355 x 4</td>
</tr>
</tbody>
</table>

Criteria for Using and Submitting CPT Code 99354
1. The services meet the code 99354 duration requirement when the practitioner has spent an extra 30 to 74 minutes in addition to a standard E/M service.
2. Services must be Medically Necessary during the prolonged E/M service.
3. The duration and the content of the evaluation and management code must be documented in the medical record.

Examples of Improper Uses of CPT Code 99354
1. Total physician direct face to face services that is equal or less than the threshold time of the E/M service.
2. Time spent on rendering therapies or other services that are paid separately.
3. Services/activities conducted during the first thirty (30) minutes of E/M service.
4. Discussions that apply to non-covered service or conditions.
5. The time spent by office staff with the patient, or time that the patient remains unaccompanied in the office.
6. Inefficient application of clinical services that result in prolonged face-to-face time in the absence of documented necessity.

Criteria for Using and Submitting CPT Code 99355
1. Time spent is supported by the clinical documentation that indicates the medical complexity and Medical Necessity.
2. Only to be used in conjunction with 99354.

References

Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations (CPG 111)


