

Physical Therapy Evaluation

CPT® Assistant.

August 2017; Volume 27: Issue 8

Physical Therapy Evaluations

The Current Procedural Terminology (CPT®) 2017 code set includes significant revisions to the coding and descriptions for physical therapy evaluations and re-evaluation services in the Medicine/Physical Medicine and Rehabilitation (PM&R) subsection. New codes (97161-97163) that describe three levels of physical therapy evaluation and one additional code (97164) for re-evaluation were created. In addition, extensive guidelines were added. The codes that were previously used to report these services were deleted and replaced with these new codes. Previously published articles addressed occupational therapy and athletic training evaluation and re-evaluation codes, however, this article provides an overview of physical therapy evaluation and re-evaluation codes.

►Physical Therapy Evaluations◄

#●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.

#●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.

Coding Tip

The definition of terms in the Physical Medicine & Rehabilitation section are not the same as those in the Evaluation and Management Services section (99201-99350). Do not use the **Definitions of Commonly Used Terms** in the Evaluation and Management (E/M) Guidelines for physical medicine and rehabilitation services.

The new physical therapy evaluation codes were developed through a process involving the American Medical Association (AMA) CPT Editorial Panel, the American Physical Therapy Association (APTA), and other professional societies. Prior to 2017, only one code (97001) was available to report an initial physical therapy evaluation service. For 2017, three new codes (97161, 97162, 97163) replaced code 97001. These new codes describe increasing evaluation complexity—low, moderate, and high. At a minimum, each of the components noted in the code descriptor must be documented in order to report the selected level of physical therapy evaluation. For re-evaluation, code 97164 replaces code 97002. The introductory guidelines to the Physical Therapy Evaluations subsection in the CPT code set provide important information about the correct reporting of code 97164.

Determining the Correct Level of Evaluation

The determination of which physical therapy evaluation code (low, moderate, or high complexity) to report is dependent upon clinical decision making and the nature of the patient's condition (severity). Therefore, in order to report the selected level of physical therapy evaluation, each of the following components noted in the code descriptors must be documented. Physical therapy evaluations include the following components:

- History
- Examination
- Clinical decision making
- Development of a plan of care

In addition, coordination, consultation, and collaboration of care with physicians, other qualified health care professionals, or agencies must be provided consistent with the nature of the problem(s) and the needs of the patient, family, and/or other caregivers.

Coding Tip

Standardized tests and measures are used by physical therapists during evaluation and re-evaluation to provide objective and measurable data related to an individual's presentation and progression through therapy. A standardized patient assessment instrument and/or measurable assessment of functional outcome would include any tool, test, or measure designed to demonstrate the overall impact of an episode of therapy.

Definitions

As previously mentioned, deciding which physical therapy evaluation code (low, moderate, or high complexity) to report is dependent upon clinical decision making and the nature of the patient's condition (severity). Therefore, the following definitions of personal factors and body regions, systems, and structures, which are used to indicate the area of evaluation and to describe the level of the evaluations, are provided below.

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:

- For the musculoskeletal system: the assessment of gross symmetry, gross range of motion, gross strength, height, and weight.
- 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).
- For the cardiovascular pulmonary system: the assessment of heart rate, respiratory rate, blood pressure, and edema.
- 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.

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.

Clinical Example (97161)

A 45-year-old female presents for 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.

Description of Procedure (97161)

The medical and medication histories are reviewed. The patient's self-reported and/or performance-based measurement outcome tool is reviewed. An examination is performed to determine the degree of impairments, activity limitations, and participation restrictions. This includes, but is not limited to, a review of systems, tests, and measures (eg, range of motion, muscle strength, neurological status, limitations in gait mechanics, functional walking speed, and weight-bearing status). The patient's and/or family/caregiver's questions are answered as appropriate throughout the evaluation. Interpretation of the patient's response to tests and measures is recorded to assist with development of a plan of care. Clinical decision-making is of low complexity, consistent with the composite of the patient presentation and evaluation criteria in the code descriptor.

Clinical Example (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.

Description of Procedure (97162)

The medical and medication histories are reviewed. The patient's self-reported and/or performance-based measurement outcome tool is reviewed. An examination is performed to determine the degree of impairments, activity limitations, and participation restrictions. This includes, but is not limited to, a review of systems, tests, and measures (eg, range of motion, muscle strength, neurological status, limitations in gait mechanics, functional walking speed, stair safety, appropriate use of assistive devices, posture assessment, and cardiopulmonary changes). The patient's and/or family/caregiver's questions are answered as appropriate throughout the evaluation. Interpretation of the patient's response to tests and measures is recorded to assist with development of a plan of care. Clinical decision-making is of moderate complexity, consistent with the composite of the patient presentation

and evaluation criteria in the code descriptor.

Clinical Example (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.

Description of Procedure (97163)

The medical and medication histories are reviewed. The patient self-reported and/or performance-based measurement outcome tool is reviewed. An examination is performed to determine the degree of impairments, activity limitations, and participation restrictions. This includes, but is not limited to, a review of systems, tests, and measures. Tests and measures of impairments that are performed include neuromuscular status (eg, muscle tone, myotomes, dermatomes, reflexes); the peripheral nerve root system (eg, thoracic outlet, brachial plexus, cervical nerve root symptoms); the musculoskeletal system (eg, range of motion, muscle strength, accessory joint mobility of the cervical thoracic outlet region); cardiovascular signs and symptoms in response to increased oxygen demand with exercise or activity, including observational changes (eg, color, diaphoresis); heart rate, rhythm, and sounds; symptomatic vascular responses (eg, angina, claudication, and exertion scales); and cognition status. The patient's and/or family/caregiver's questions are answered as appropriate throughout the evaluation. Interpretation of the patient's response to tests and measures is recorded to assist with development of a plan of care. Clinical decision-making is of high complexity, consistent with the composite of the patient presentation and evaluation criteria in the code descriptor.

Clinical Example (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.

Description of Procedure (97164)

The updated patient medical history is reviewed, and current medications are confirmed. The patient's self-reported and/or performance-based measurement outcome tool is reviewed. The examination during reevaluation includes measurement of gross range of motion as well as segmental mobility, neurologic status, and muscle strength. The patient's and/or family/caregiver's questions are answered as appropriate throughout the reevaluation. Interpretation of the patient's response to tests and measures is recorded to assist with updating the plan of care. ◆