Established Patient Re-evaluation

Optum Health Solutions Musculoskeletal (MSK) Utilization management policy
Policy number: 362

Effective Date: 4/25/2024

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Policy Statement

Established patient re-evaluation services are appropriate and medically necessary when all of the following conditions are met:

- Benefit coverage criteria are satisfied
- 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 judgement about continued care
  - Making a professional judgement about revising goals and 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

Purpose

This policy has been developed to describe the criteria that Optum uses to conduct utilization review (UR) determinations concerning the appropriateness and medical necessity for reporting of established patient re-evaluations.

Scope

In-scope*:* All in and out of network programs (exclusive of Medicare and Medicaid products for chiropractic) involving all provider types, where utilization review determinations about evaluation and management (E/M) services and/or procedural codes 97164 and 97168 are reported. This policy also serves as a resource for peer-to-peer interactions in describing the position of Optum on the application of CPT codes 97164, 97168, 99211, 99212, 99213, 99214, 99215.

Out-of-scope: Determinations concerning the level or documented performance of evaluation and management (E/M) services.

Definitions

Assessment

Assessment refers to the professional skills used to gather data by observation, patient inquiry, and may include limited objective testing and measurement to make clinical judgments regarding the patient's condition(s). Assessments determine changes in the patient's status since the last visit/treatment day and whether the planned procedure or service should be modified. Based on these assessment data, the clinician may make judgments about progress toward goals and determine that a more complete evaluation or re-evaluation (see 'Reporting Re-evaluations' below) is indicated (CMS, 2023).

Episode of care

An outpatient therapy episode is defined as the period of time, in calendar days, from the first day the patient is under care of the clinician (e.g., for evaluation and treatment) for the current condition(s) being treated by one therapy discipline until the last date of service for that discipline in that setting (CMS, 2023).

Established patient

Patient has received any professional service from the physician or other healthcare professional or another physician or other qualified healthcare professional in the same group of same specialty within the past three years (AMA, CPT®, 2023).

Established patient (physical/occupational therapy)

An established patient is one who has received professional services for an episode of care from the therapist or from another therapist of the same specialty, who belongs to the same group practices, for a particular condition. If a new problem/abnormality is encountered, then an initial evaluation should be reported (AMA, CPT®,2023).

Background

Indications for Re-evaluation

Re-evaluations are usually focused on the current treatment and might not be as extensive as initial evaluations. Continuous assessment of the patient's progress is a component of ongoing therapy services and is not payable as a re-evaluation. A re-evaluation is not a routine, recurrent service but is focused on evaluation of progress toward current goals, making a professional judgement 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.

Indications for re-evaluation include:

- New clinical findings
- A significant change in the patient's condition
- Or failure to respond to the therapeutic interventions outlined in the plan of care (CMS, 2023).

Re-evaluation requires clear documentation of the following:

As adapted from the APTA (2018)

- Updated relevant history
- Current subjective symptoms
- Evaluation of the musculoskeletal/nervous system through physical examination
- Standardized patient-important outcome assessments (e.g., measures of functional status) based on appropriate, relevant, and validated tests and tools using comparable and consistent methods
- Assessment of clinically meaningful progress in primary and secondary outcomes
- Identification of appropriate further intervention(s)
- Updated goals that are consistent with changes in a patient's condition and the likelihood of further clinically relevant improvement with treatment
- Frequency and duration of skilled- and self-care
- Timeframe for re-evaluation of response to treatment and to determine the need for a change in the current plan of care

Coding information

Note: The Current Procedural Terminology (CPT) codes listed in this policy may not be all inclusive and are for reference purposes only. The listing of a service code in this policy does not imply that the service described by the code is a covered or non-covered health service. Coverage is determined by the member's benefit document.

Code	Description
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
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
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. (No time reference)
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history, examination and/or straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

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References

American Medical Association. CPT® 2023, Professional Edition

American Physical Therapy Association (APTA). Elements of Documentation Within the Patient/Client Management Model. Updated 01/31/2018.

CMS Medicare Benefit Manual Chapter 15. Rev 12299.

Policy history and revisions

Date	Action
12/13/2007	Utilization Management Committee approved the inactivation of the policy
10/10/2008	Quality Improvement Committee approved inactivation of policy
12/11/2008	Revised policy submitted to the UMC for approval. Policy updated to include current authoritative sourced information. Decision Guide introduced.
4/30/2009	Annual review and approval completed
4/8/2010	Annual review and approval completed
10/26/2010	Policy rebranded to “OptumHealth Care Solutions, Inc. (OptumHealth)”
4/7/2011	Annual review and approval completed
4/19/2012	Annual review and approval completed
4/18/2013	Annual review and approval completed
4/17/2014	Annual review and approval completed; Table 2 and References section updated. Policy rebranded to “Optum” by OptumHealth Care Solutions, Inc.”
4/16/2015	Annual review and approval completed
4/21/2016	Updated references and Tables 1&2. Annual review and approval completed
4/20/2017	Policy revised to align with CMS terminology and positions. “Policy Statement” revised. New physical and occupational CPT codes added. “Reporting and Re-evaluations” section revised. “Related Policies” updated.
4/26/2018	Annual review and approval completed; no significant changes made to the document
4/25/2019	Annual review and approval completed; no significant changes made to the document
4/23/2020	Annual review and approval completed; updated references
4/22/2021	Annual review and approval completed. Updated coding information with new descriptors for CPT codes 99211-99215. Updated references
5/3/2022	Annual review and approval completed. Updated references.
9/29/2022	Updated legal entity name “OptumHealth Care Solutions, LLC.” to *Optum™ Physical Health (“Optum”) includes OptumHealth Care Solutions, LLC; ACN Group IPA of New York, Inc.; ACN Group IPA of California, Inc. d/b/a OptumHealth Physical Health of California; Managed Physical Network, Inc.; and OrthoNet Holdings, Inc. which includes OrthoNet New York IPA, Inc., OrthoNet West, Inc., OrthoNet, LLC, OrthoNet of the South, Inc.
4/27/2023	Annual review and approval completed; no significant changes made to the document. Updated contact email from policy.inquiry@optumhealth.com to phpolicy_inquiry@optum.com.
1/10/2024	Annual review completed, no substantive changes. Approved by Optum Clinical Advisory Committee

4/25/2024	Annual review and approval completed. Document content transitioned to new policy template. No significant changes made to the document.