Established Patient Re-evaluation

Table of Contents

Related Policies

Skilled Care Services
Application of Clinical Algorithms
Reporting Spinal Chiropractic Manipulative Treatment (CMT) Levels
Documentation Requirements for Reimbursement of E/M Services
E/M Services Quick Reference Table
Modifier -25
PT & OT Re-evaluation Reimbursement Policy

Policy Number	**362**
Original Effective Date:	1/1997
Current Approval Date:	4/27/2023
Next Review:	4/2024
Category:	Determination

Policy Statement

Optum* by OptumHealth Care Solutions, LLC considers the reporting of established patient re-evaluation services to be appropriate and/or 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 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.

Purpose

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

Key Policy Question

What are the circumstances that support the addition of a separate and distinct re-evaluation during the course of care for an established patient?

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

The following definitions apply to this policy:

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/or determine that a more complete evaluation or re-evaluation (see 'Reporting Re-evaluations' below) is indicated.[1]

Episode of care

The consultation and skilled care provided by a clinician…

- for a new health problem or condition, which begins with the initial evaluation and ends with the reporting of discharge status; or
- for a previously treated health problem or condition, which is preceded by at least 3 months without treatment; or
- for a previously treated health problem or condition, which is preceded by a separation from care due to a surgical procedure directly related to the health problem or condition; or
- for a chronic/recurrent health problem or condition, which consists of a series of treatment intervals marked by one or more brief separations from care.

An episode may include the evaluation and treatment related to multiple conditions.

Established patient (chiropractor)	An established patient is one who has received professional services from the physician [including chiropractor] or from another physician of the same specialty who belongs to the same group practice, during the past three years.[2]
Established patient (physical/occupational therapist)	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 practice, for a particular condition. If a new problem/abnormality is encountered, then an initial evaluation should be reported.[3]
Patient-reported outcomes	Summary data on patient-reported outcomes (PROs) are important to ensure healthcare decision makers are informed about the outcomes most meaningful to patients.[4]
Re-evaluation	The re-evaluation provides additional objective information not included in other documentation (eg, assessments of progress between visits). Re-evaluation is separately reportable and is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient's condition or functional status that was not anticipated in the plan of care.[1]

Background

Introduction

"Reassessments [and re-evaluations] are an integral component of case management and should be made following an appropriate period of care…A knowledge of the natural history of the condition greatly facilitates decisions concerning the timing of reassessment."[5] The requirements for reporting patient re-evaluations have been described.[2,6-8] Similarly, the documentation standards for substantiating the performance of established patient re-evaluations have been described.[9,10] The routine assessment of patient progress (eg, to assess changes in a patient's status since the last visit, and whether the planned procedure or service should be modified) is included in the services provided during a subsequent office visit and is not reportable as a re-evaluation.[1]

Indications for Reporting Re-evaluations

In contrast to assessment, a re-evaluation is focused on evaluation of progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment or terminating services. Re-evaluation requires the same professional skills as an initial evaluation. Indications for a 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.[1]

Reporting Re-evaluations

The reporting of a re-evaluation includes all of the following components:

- Data collection:
  - Updated relevant history
  - Current subjective symptoms
  - Pertinent physical examination findings
  - 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

- Outcomes assessment:
  - Deciphering effectiveness of intervention(s)
    - Assessment or clinically meaningful progress in primary and secondary outcomes
    - Correlation of outcomes with anticipated goals
  - Identification of barriers to improvement/recovery

- Clinical decision-making:
  - Interpretation of symptoms and exam findings to determine the priority/focus of treatment
  - Judgments about the necessity of continued skilled care services
  - Identification of appropriate further intervention(s)

- Plan of care:
  - Goals:
    - Updated person-centered goals that are consistent with changes in a patient's condition and the likelihood of further clinically relevant improvement with treatment
  - Interventions:
    - Any modification of current intervention(s)
    - Description and implementation plan for any appropriate new intervention(s)
  - Schedule:
    - 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	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 and/or examination and 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.

References

1. Medicare Benefit Policy Manual. Chapter 15 – Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance. *Centers for Medicare & Medicaid Services* Rev. 11771, 12/30/2022; Accessed 02/10/2023: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

2. Current Procedural Terminology (CPT) Manual – Professional Edition. *American Medical Association*

3. Physical therapy evaluation coding. Adapted from the *CPT Assistant*. Sept. 2001 *American Medical Association*

4. Patrick DL, Guyatt GH, Acquadro C, on behalf of the Cochrane Patient Reported Outcomes Methods Group. Patient-reported outcomes (Chapter 18) in: Cochrane handbook for systematic reviews of interventions (Higgins JP, Green S, editors). J*ohn Wiley & Sons*; 2011

5. Haldeman S. Guidelines for Chiropractic Quality Assurance and Practice Parameters. Gaithersburg, MD: *Aspen Publishers* 1993; Chapter 9:133-137

6. Guidelines: physical therapy documentation of patient/client management. *American Physical Therapy Association*, updated 05/19/2014; accessed 02/10/2023: https://www.apta.org/siteassets/pdfs/policies/guidelines-documentation-patient-client-management.pdf

7. Levinson SR. Practical E/M – Documentation and Coding Solutions for Quality Patient Care 2008. *American Medical Association*

8. Guide to Physical Therapist Practice, 3rd edition. 2014. *American Physical Therapy Association*: http://www.apta.org/

9. Defensible Documentation for Patient/Client Management. *American Physical Therapy Association* – Guide. Updated 12/08/2015; Physical Therapy Documentation of Patient and Client Management | APTA

10. Clinical Documentation Manual, 3rd edition. 2012; *American Chiropractic Association:* http://www.acatoday.org/

Policy History/Revision Information

Date	Action/Description
12/13/2007	Utilization Management Committee approved the inactivation of the policy
1/10/2008	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
4/08/2010	Annual review and approval completed
10/26/2010	Policy rebranded to "OptumHealth Care Solutions, Inc. (OptumHealth)"
4/07/2011	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 "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 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
5/03/2022	Annual review and approval completed; updated references
6/29/2022	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.
4/27/23	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.

Contact Information

Please forward any commentary or feedback on Optum utilization management policies to: phpolicy_inquiry@optum.com with the word "Policy" in the subject line.

The services described in Optum* by OptumHealth Care Solutions, LLC policies are subject to the terms, conditions and limitations of the Member's contract or certificate. Optum reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Optum's administrative procedures.

Certain internal policies may not be applicable to self-funded members and certain insured products. Refer to the member's Summary Plan Description (SPD) or Certificate of Coverage (COC) to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member's SPD or COC, the member's SPD or COC will govern.