New Occupational Therapy Evaluation Codes

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New Occupational Therapy Evaluation Codes

The Current Procedural Terminology (CPT®) 2017 code set includes significant revisions to the coding and descriptions for occupational therapy evaluation and re-evaluation services in the Medicine/Physical Medicine and Rehabilitation subsection. Three new codes (97165-97167) were created to describe three levels of occupational therapy evaluation and one code (97168) for re-evaluation. The codes (97003, 97004) that were previously used to report these services were deleted and replaced with these new codes (97165-97168) and extensive guidelines were added. This article provides an overview of these changes.

New Codes

#97165
Occupational therapy evaluation, low complexity, requiring these components:

- 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 (ie, 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 (eg, 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.
#97166
Occupational therapy evaluation, moderate complexity, requiring these components:

- 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 (ie, 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 (eg, 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.

#97167
Occupational therapy evaluation, high complexity, requiring these components:

- 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 identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and
- Clinical decision making 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 (eg, 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.
#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.

The new occupational therapy evaluation codes were developed through a process that involved the American Medical Association (AMA) CPT Editorial Panel, the American Occupational Therapy Association (AOTA), and other professional societies. Prior to 2017, only one code (97003) was available to report an initial occupational therapy evaluation service. For 2017, code 97003 was replaced with new codes 97165, 97166, and 97167. These new codes describe increasing evaluation complexity; low, moderate, or high. At a minimum, each of the components noted in the code descriptor must be documented, in order to report the selected level of occupational therapy evaluation. For re-evaluation, code 97168 replaces code 97004. The introductory guidelines to the Occupational Therapy Evaluations subsection in the CPT 2017 code set provide important information for correct reporting of this code.

Occupational therapy evaluations include an occupational profile, medical and therapy history, relevant assessments, and development of a plan of care, which reflects the therapist's clinical reasoning and interpretation of the data. Coordination, consideration, 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.1

The new occupational therapy evaluation codes have descriptor language and guidelines that are derived from AOTA evidence-based clinical practice guidelines and the Occupational Therapy Practice Framework: Domain & Process (2nd Edition)[OT Framework], which is a foundational document that sets forth the approach, structure, and language of occupational therapy.2 This alignment between CPT coding and clinical practice reinforces optimal patient care. By conducting an occupational profile, performing standardized tests and measures, and documenting the breadth of patient functional concerns that occupational therapists consider, the full scope of occupational therapy evaluation services may be communicated to others.

Determining the Correct Level of Evaluation

Occupational therapy evaluations include the following components:

- Occupational profile and client history (medical and therapy)
- Assessments of occupational performance
- Clinical decision making
- Development of a plan of care

Identifying and reporting the complexity level of an evaluation focuses on the first three of these components: profile and history, assessment, and clinical decision making. These three components must be documented in the medical record to support the choice of a code level. The development of a plan of care is part of the overall evaluation process and must reflect the selection of the evaluation code level.
The documentation must reflect the therapist's attention to each of the components in the context of the entire evaluation and address the patient's needs. In order to move to a

higher level of evaluation, all three components must be of the higher level. For example, if the profile and history are moderate and the assessment of occupational performance and identification of deficits is moderate, but the clinical decision making component is high, the evaluation would be reported as 'moderate' because not all three components met a high level of complexity. Each of the three components is discussed below.

Occupational Profile and (Medical and Therapy) History

The therapist uses the occupational profile to frame the evaluation of the patient. The profile and history contribute to the determination of the code level. Table 1 outlines the three levels of occupational profile and history that are based on the definitions in the CPT code descriptors.

Table 1. Levels of Profile and History

CPT Code/Level	Occupational Profile and History
Low complexity (97165)	An occupational profile and medical and therapy history that includes a **brief** history, including review of medical and/or therapy records relating to the presenting problem.
Moderate complexity (97166)	An occupational profile and medical and therapy history that includes an **expanded** review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance.
High complexity (97167)	An occupational profile and medical and therapy history that includes review of medical and/or therapy records and **extensive** additional review of physical, cognitive, or psychosocial history related to current functional performance.

The key terms to consider when differentiating and choosing a level for this component, in addition to the types and extent of the history and records review, are brief, expanded, and extensive. While these terms are somewhat subjective and require the therapist's clinical judgement, the brief review relates only to the presenting problem and it is relatively isolated in relation to functional performance. The expanded and extensive reviews relate to the client's current functional performance in light of past medical and therapy history, and can be deemed extensive with significant length of illness, comorbidities and amount of documented physical, cognitive and/or psychosocial history.

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 (eg, 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 (eg, recent fracture) and what is causing the patient to seek

occupational therapy services. The amount and type of history (eg, from the referring physician or qualified health care professional) reviewed depends on what the occupational therapist needs to know (eg, postsurgical precautions, comorbidities) to continue with an assessment and development of a plan of care. Again, the criteria for brief, expanded, and extensive are applied to determine the level.
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. In the code descriptor, 'performance deficits' refer to occupations in which the client is experiencing problems. Occupations are defined in the OT Framework's Table 1, Occupations.2 This linkage between performance and skills deficits supports the emphasis of occupational therapy on occupational performance. For the three levels of occupational performance assessments that are based on the definitions of the CPT code descriptors, see Table 2.

Table 2. Levels of Assessment of Occupational Performance

CPT Code/Level	Occupational Performance Assessment
Low complexity (97165)	An assessment(s) that identifies **1 to 3 performance deficits** (ie, relating to physical, cognitive, or psychosocial skills) that results in activity limitations and/or participation restrictions
Moderate complexity (97166)	An assessment(s) that identifies **3 to 5 performance deficits** (ie, relating to physical, cognitive, or psychosocial skills) that results in activity limitations and/or participation restrictions
High complexity (97167)	An assessment(s) that identifies **5 or more performance deficits** (ie, relating to physical, cognitive, or psychosocial skills) that results in activity limitations and/or participation restrictions

The count of performance deficits is only one factor in assigning the level of code complexity, ie, 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. Given these other factors, therapists must exercise clinical judgment as to whether the three deficits fall closer to a low or moderate complexity evaluation in the specific client scenario with which they are presented.

Identification, Assessment, and Determination

Standardized assessment tools as well as observation of performance are used to identify a performance deficit(s). All assessment tools and observation of occupational performance should be documented. Note that the third evaluation component clinical decision making includes analysis of assessment. See the clinical decision making section below for a discussion of how assessment is included in clinical decision making.

Performance Deficits

Performance deficits and the three categories of skills are defined as follows:
Performance deficits refer to the inability to complete activities due to the lack of skills in one or more of the categories below (ie, relating to physical, cognitive, or psychosocial skills):

Physical skills: Physical skills refer to body structure or body function (eg, 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.2

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. As previously noted, 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 World Health Organization's [WHO's] International Classification of Functioning, Disability and Health3 is a useful tool in understanding performance deficits that result in activity limitations, which is defined as 'difficulties an individual may have in executing activities'3 or participation restrictions, which is defined as 'problems an individual may experience in involvement in life situations.'3

Defining deficits that result in activity limitations and/or participation restrictions will enable the creation of goals the occupational therapy plan will address. The CPT code set's definitions can be understood in context to and in relation to the OT Framework's Table 1 (Occupations)2,
as well as the concepts in Table 2 (Client Factors)2 and Table 3 (Performance Skills).2

The therapist's clinical judgment about the overall needs of the patient, the patient's expectations of the episode of care, and the overall complexity of the patient presentation will

dictate the number of deficits identified.

Clinical Decision Making

The third component that must be considered in determining the level of the evaluation service is clinical decision making. Although a separate component, clinical decision making occurs throughout the evaluation process. Table 3 outlines the three levels of complexity for clinical decision making based on the definitions of the CPT code descriptors.

Table 3. Levels of Complexity for Clinical Decision Making

CPT Code/Level	Clinical Decision Making
Low complexity (97165)	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 (eg, physical or verbal) with assessment(s) is **not necessary** to enable completion of evaluation component.
Moderate complexity (97166)	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 (eg, physical or verbal) with assessment(s) is necessary to enable completion of evaluation component.
High complexity (97167)	Clinical decision making of **high analytic complexity,** which includes an analysis of the occupational profile, analysis of data from **comprehensive assessment(s),** and consideration of **multiple treatment options.** Patient may present with comorbidities that affect occupational performance. **Significant modification** of tasks or assistance (eg, physical or verbal) with assessment(s) is **necessary to enable patient to complete evaluation component.**

The CPT definitions and code selection guidelines clearly identify factors to consider in determining the level of clinical decision making. These factors include the level of assessment, presence of comorbidities, and the number of treatment options.

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

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. Table 4 outlines indicators for the levels of complexity relative to the number of treatment options considered.

Using the information gathered throughout the evaluation, the occupational therapist may have to consider limited treatment options, several treatment options, or multiple treatment options. Treatment options considered typically fall into one or more of the following approaches: create, promote, establish, restore, maintain, modify, and prevent in the OT Framework. The therapist and the client must collaboratively decide if a treatment plan to restore the performance skills is more appropriate given the medical history, performance deficits, and goals of the client. For example, following an orthopedic intervention such as a shoulder arthroplasty or an open-reduction internal-fixation (ORIF) of the upper extremity, the treatment options are typically limited. The therapist typically works to restore the function of the joint to alleviate the performance deficits.

Following a cerebrovascular accident (CVA) with hemiparesis, the therapist may have to consider multiple treatment options. These options must take into account the occupational profile, current status, and performance deficits. If the client's goal is to return to work, the therapist must decide if the treatment plan should focus on restoring the use of the paralyzed side, or modifying the task and habits so that the person is able to overcome performance deficits. Furthermore, the therapist must consider how to implement the plan. Finally, for a very complex client who suffered a traumatic brain injury (TBI), multiple traumatic fractures, and has a complex history including multiple comorbidities that impact performance, the therapist is likely to consider multiple treatment options, including restoring function related to the fractures, modifying tasks and environments, creating new habits that allow the person to participate in basic ADLs, such as toileting, promoting new routines to integrate health care management along with other potential treatment options. 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.

Table 4. Levels and Number of Treatment Options

CPT Code/Level	Number of Treatment Options
Low complexity (97165)	Consideration of a limited number of treatment options
Moderate complexity (97166)	Consideration of several treatment options
High complexity (97167)	Consideration of multiple treatment options

Time

The new occupational therapy evaluation and re-evaluation CPT codes are service codes and not time-based codes. Although typical times are included with each code descriptor,

time is not the determining factor in code selection (see Table 5). Instead, it is only a general guideline about the typical face-to-face time with the patient and/or family.

Table 5. Typical Face-to-Face Time

CPT Code/Level	Typical Face-to-Face Time* with Patient and/or Family
Low complexity (97165)	30 minutes
Moderate complexity (97166)	45 minutes
High complexity (97167)	60 minutes

*The typical times identified should not be construed as either requirements or limits.

Re-evaluation

Code 97168 is used to report occupational therapy re-evaluation that is based on an established and ongoing plan of care. This is in contrast to the evaluation codes that include development of a plan of care. The AOTA describes a re-evaluation as the 'reappraisal of the patient's performance and goals to determine the type and amount of change that has taken place.'2 While there aren't different levels of codes for re-evaluation, the CPT code set guidelines provide similar guidance for the re-evaluation components, as outlined in Table 6.

Table 6. Re-evaluation Components

CPT Code Component	Re-evaluation
Assessment	An assessment of changes in patient functional or medical status with revised plan of care
Occupational Profile	An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals
Plan of Care	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.

Medicare and other third-party payers may have particular rules about when a re-evaluation may be reimbursed. The CPT code set guidelines only describe the components required to report the service. For example, the evaluations codes and the re-evaluation code describe typical time of 30 minutes for face-to-face interaction with the patient and/or family.

Again, this is not to be considered a requirement or a limit on time.

References

1. American Medical Association. CPT Professional 2017.
Chicago, IL; AMA:2016.
2. AOTA. Occupational Therapy Practice Framework: Domain & Process, 2nd Ed. Bethesda, MD; AOTA Press: 2009.
3. World Health Organization. International Classification of Functioning. Disability and Health: ICF. Switzerland: Geneva; WHO: 2001.

