New Occupational Therapy Evaluation CPT® Codes: Coding Overview and Guidelines on Code Selection

Catherine Brennan, MA, OTR/L, FAOTA
Consultant and Peer Review Coordinator
Minnesota Occupational Therapy Association
St. Paul, Minnesota

Mary Jo McGuire MS, OTR/L, OTPP, FAOTA
Clinical Assistant Professor
School of Behavioral and Health Sciences
Walsh University
North Canton, Ohio

Christina Metzler
Chief Public Affairs Officer
The American Occupational Therapy Association
Bethesda, MD

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ABSTRACT
On January 1, 2017, four new codes will go into effect for occupational therapy evaluations. The American Medical Association’s (AMA’s) Common Procedural Terminology (CPT®) 2017 Manual will list three levels of occupational therapy evaluation to replace CPT® code 97003 and one level of re-evaluation to replace CPT® code 97004 under the Physical Medicine and Rehabilitation section of the codebook. To use the correct codes in the new system, occupational therapists will have to attend to new criteria that distinguish three different levels of initial evaluation. This article provides an overview of the new evaluation codes to assist occupational therapists with making correct coding choices that reflect modern occupational therapy practice.

LEARNING OBJECTIVES
After reading this article, you should be able to:
1. Discuss how CPT describes the occupational therapy evaluation and reevaluation codes
2. Identify each component of the new occupational therapy evaluation codes
3. Describe the differences between low-, moderate-, and high-complexity occupational therapy evaluation codes
4. Select an appropriate initial evaluation code that reflects the level of complexity of the evaluation performed
5. Utilize concepts from the Occupational Therapy Practice Framework: Domain and Process, 3rd Edition (American Occupational Therapy Association, 2014) to enhance the occupational therapy evaluation process

INTRODUCTION
On January 1, 2017, new CPT codes will go into effect for occupational therapy evaluations. The American Medical Association’s (AMA’s) Common Procedural Terminology (CPT®) 2017 book will list three levels of occupational therapy evaluation and one level of re-evaluation under the Physical Medicine and Rehabilitation section of the CPT code set. The previous codes have been deleted and replaced with new codes, with new code numbers and new requirements for use (see Table 1 on p. CE-5).

To use the correct code in the new system, occupational therapists will have to attend to new criteria that distinguish three different levels of initial evaluation. This article is intended to provide an overview of the codes to assist occupational therapists with making correct coding choices that reflect modern occupational therapy practice. Three new CPT codes replace code 97003 and describe differences in complexity of evaluations, ranging from low (i.e., straightforward), designated by code 97165; to moderate (i.e., involved), designated by code 97166; to high (i.e., very complex), represented by code 97167.

Previously, when an occupational therapist performed an evaluation of a client, only one code (97003) was available to reflect the clinical work accomplished during that evaluation session. There is one re-evaluation code: code 97168.

The code descriptors and introductory guidelines for their use are published in the CPT code book and are available on AOTA’s website, at www.aota.org. New CPT code books are available in print and online from the AMA. The AMA also plans in early 2017 to publish an article explaining the codes in the CPT Assistant Newsletter, which is available by subscription (https://commerce.ama-assn.org/store).

The new codes were developed through a process involving the AMA (which develops, publishes, and owns the CPT system), the American Occupational Therapy Association (AOTA), and other professional societies. Payers, including Medicare, Medicaid, and insurance providers, use these codes to identify services for payment.

Medicare will begin using these codes on January 1, 2017, and most other third-party payers (e.g., Medicaid, insurers) will
follow this procedure by developing individual payer policies on the use of and payment for codes.

To understand how CPT described the occupational therapy evaluation and reevaluation codes, it is important to review and understand the precise language in the 2017 AMA CPT manual. It provides the following introduction to the codes for Occupational Therapy Evaluation:

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. (AMA, 2016, p. 664)

The definition follows the approach to evaluation in the Occupational Therapy Practice Framework: Domain and Process, 3rd Edition (Framework; AOTA, 2014). The Framework will be referenced throughout this article, as it provides important direction for conducting appropriate, best-practice evaluations.

The new evaluation code descriptions in the CPT code set promote optimal occupational therapy practice. By conducting an occupational profile, completing assessments, and presenting the breadth of client functional concerns, occupational therapists capture and express the distinct value of occupational therapy evaluation services. The occupational therapy evaluation process communicates to others the full scope of occupational therapy practice. In this sense, the codes can be a tool to promote the distinct value of occupational therapy.

**DETERMINING THE CORRECT LEVEL OF EVALUATION**

The new CPT evaluation code descriptors and guideline language define the exact elements of an evaluation:

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

Identifying and reporting the complexity level of an evaluation focuses on the first three of these factors—profile and history, assessment and determination of deficits, and clinical decision making. These three factors must be “scored” and defensible documentation written as part of the medical record to support the choice of a code level.

The three components—occupational profile and history, assessment, and clinical decision making—are the factors that payers and others will review to ensure that the therapist has chosen the right code level. The documented plan of care reflects the process and outcomes and the therapist’s attention to each of the CPT factors in the context of the whole evaluation to meet the client’s needs.

The three components are what must be validated in choosing a level, but a sufficient evaluation must be provided as appropriate to occupational therapy practice. Why a particular level was chosen should be supported in the documentation of the evaluation.

To assist in selecting an evaluation code level, the codes direct that each of the three previously noted components must be given a complexity level: low, moderate, or high.

**CHOOSE AN APPROPRIATE LEVEL**

Levels must be determined specifically for each of the three components in order to choose the correct code. For 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 must still be coded moderate. Therapists must remember that they are ethically, and in some cases legally, required to choose and report the correct code. The code design considers the presenting client condition, the analytical work of the therapist, and the assessment and identification of the scope and nature of the client’s performance concerns and goals. A proper evaluation involves a broader view and other components. But choosing a level is necessary to report the correct code.

The following describes how each of the three components affects the code level based on the language of the actual code descriptors in the manual.

**Level of Profile and History**

The occupational therapy process as described in the Framework is reflected in the code language, especially in its requirement of completing an occupational profile and a medical and therapy history. The key terms in CPT to consider when differentiating and choosing a level for this component, in addition to the types and extent of history and records, are Brief (Low), Expanded (Moderate), and Extensive (High), which are related to categorizing the elements of occupational profile and history to determine the level.

**Occupational Profile**

The occupational profile provides an understanding of the client’s occupational history and experiences, patterns of daily living, interests, values, and needs. The client’s problems and concerns about performing occupations and daily life activities are identified as part of the profile. The client’s priorities for outcomes are also determined.

To decide on the level of occupational profile that must be completed, the therapist must consider the presenting problem(s), the reason(s) for referral, and the client’s goals.
**Client Medical and Therapy History**
The client's medical and therapy history is reviewed and considered in order to identify issues that may affect the current problem. How much of the history is necessary depends on why the client is seeking services and what the occupational therapist needs to know to continue with assessing and developing the plan of care. The referral for therapy may also provide additional information. It can also come from medical records of past and current care.

**Physical, Cognitive, or Psychosocial History**
To achieve expanded (moderate) or extensive (high) levels of profile and history, the therapist must also review with the client their physical, cognitive, or psychosocial history related to current functional performance.

**Level of Assessment of Occupational Performance**
The second component in determining the level of the CPT evaluation service considers factors related to both the assessment process and the identification of performance deficits resulting in activity limitations and/or participation restrictions. Performance deficits that do not result in activity limitations and/or participation restrictions that are meaningful to the client do not count.

**Assessment Process**
The therapist should consider all the information gathered in the history and occupational profile, and the data from the assessment process, to determine (with the client) the priority of occupational performance deficits to be addressed.

Ideally, the therapist will use standardized assessments to identify a performance deficit and decide with the client whether that deficit should be addressed. The physical, cognitive, and psychosocial skills areas identified by CPT encompass broad areas of skills, but these may be broken into component skills for assessment and possibly for intervention. Components of skills, such as range of motion or ability to sequence, should also be assessed, including in physical, cognitive, and psychosocial areas.

Lack of skills that affect activity and participation may also be identified by non-standardized assessment, although many payers are beginning to require standardized approaches. All assessment tools and approaches should be explicitly documented in the medical record, and the rationale supporting the use of non-standardized tools is highly recommended. The CPT does not fully encompass all that occupational therapy may or should address in the plan. Documentation is where the clinician must explain performance as context and environment.

The International Classification of Functioning, Disability and Health (World Health Organization [WHO], 2001) is also a useful tool in understanding performance deficits that result in activity limitations or participation restrictions: "Activity limitations are difficulties an individual may have in executing activities" and "participation restrictions are problems an individual may experience in involvement in life situations" (p. 123).

The Framework does not define or use the term performance deficits; the Framework and occupational therapy practice focus on the capacities of clients and their skills or potential skills. However, the CPT definitions provide ample areas in which to identify client needs and goals. Defining deficits is viewed in the CPT context as the process of identifying what areas or goals the occupational therapy plan will address. The CPT definitions can be understood in relation to the Framework’s Table 1: Occupational Performance as well as the concepts in Table 2: Client Factors and Table 3: Performance Skills.

Performance deficits are really the “why” of an intervention plan. Documentation is where the clinician must explain performance deficits’ impact on functional performance, and goals in the plan of care should reflect the outcome performance to be achieved.

It is important to note that the count of client-relevant performance deficits is only one factor in assigning the level of the code. The complexity of the occupational profile and medical history, and the complexity of the clinical reasoning, which result in the development of the plan of care, must also be considered.

Because the number of deficits will be subject to review as the new codes are implemented, documentation of these is...
very important. The therapist’s clinical judgment and reasoning about the overall needs of the client, the client’s expectations for this episode of care, and the overall complexity of the presenting client situation will dictate the number of deficits identified.

**Level of Clinical Decision Making**

The new CPT codes for occupational therapy evaluation identify a component of clinical decision making that affects the code level selected. Best practice in occupational therapy requires clinical reasoning to occur throughout the evaluation process: in decisions about the questions to ask in the occupational profile and history, in the choice of assessments and tests used to measure performance, and in the identification and prioritization of goals and outcomes. Although clinical decision making is pervasive, the CPT guidelines for code selection allow for consideration of certain variables in determining a level of clinical decision making. Identifying and documenting the complexity of clinical reasoning used at each step of the process will validate the chosen level of evaluation code.

**Specified Criteria for Clinical Decision Making Level**

The CPT definitions and code selection guidelines provide clear delineation of factors that can be related to not only determining the level of clinical decision making component, but also factors that affect other components. The CPT code language speaks to interrelated factors and thus an interrelated process that must be considered in determining the level of clinical decision making.

**Assessment Process.** As noted and defined in the previous section on assessment and performance deficit identification, the clinical decision making section in the CPT describes levels of analysis and assessment that are related to determining the level of both the assessment and clinical decision-making component. The key words are Problem-focused (Low), Detailed (Moderate), and Comprehensive (High).

**Impact of Comorbidities.** The type, number, and complexity of comorbidities affecting occupational performance or that result in participation restrictions are identified as affecting the evaluation code level, in relation to clinical decision making. Only those that impact performance should be considered.

For example, a secondary diagnosis of chronic obstructive pulmonary disease may influence the client’s breathing and fatigue level, affecting completion of desired activities of daily living (ADLs).

**Assessment Modification and Need for Assistance.** The CPT language describes the levels of assistance or modification that may be needed to enable completion of assessments that contribute to the level of clinical decision making. The language also gives examples that assistance may be physical, verbal, or some other form. Any modifications or adjustments in assessing performance deficits and activity limitations should be documented to show the relationship to the level of evaluation code chosen. The key words for modifying tasks in assessment or assistance are no modification or assistance (low), minimal to moderate (moderate), and significant (high).

**Selection of Interventions.**

Selecting may be simple or complex. This affects the level of clinical decision making. For instance, treatment of hemiparesis may involve choosing among several options for treatment, adaptation, or compensatory activities. But treatment of an acute shoulder hemi-arthroplasty may be driven by a limited number of treatment options. The key words in the selection of interventions are limited number (low), several (moderate), and multiple (high).

The therapist considers all these factors to determine what level the component of clinical decision making should be. Note that each factor in clinical decision making can be individually determined. The factors are considered by the therapist individually and documented individually, but it is the therapist’s view of how complex the overall process was that affects the level.

**CLINICAL VIGNETTES: IDENTIFYING THE CORRECT EVALUATION LEVEL**

**Low-Complexity Occupational Therapy Evaluation (97165)**

The client was a 69-year-old retired female who fell at home, sustaining a closed distal radius fracture to the right dominant wrist. On her return visit to the physician, she had limited range of motion (ROM) and was referred to occupational therapy for ROM hand strengthening.

The occupational therapist reviewed the occupational profile and the medical and therapy history and observed the client performing activities. The therapist assessed sensation, strength, ROM, and edema. Sensation was normal and there were no vascular issues. Mild edema was observed to be present in the client’s wrist and digits. The therapist evaluated her ROM and found it was within normal limits at the shoulder, normal for elbow extension and flexion, and moderately limited in the wrist and forearm. Grip and pinch strength were decreased compared with the non-dominant hand, making it difficult for her to perform dressing and home management activities, such as cleaning. The occupational therapist had the client complete the Disabilities of the Arm, Shoulder and Hand Assessment (Kennedy, Beaton, Solway, McConnell, & Bombadier, 2011).

Based on the client’s occupational profile, history, and assessment results, the occupational therapist developed a plan of care addressing performance deficits in ADLs and instrumental ADLs (IADLs) due to decreased active range of motion, decreased strength, limits in gripping, and increased edema.

The therapist chose the low-complexity evaluation code for the following reasons:

- Medical history was brief; the presenting problem was the primary focus of the evaluation.
Three performance deficits were to be addressed in the plan of care due to wrist fracture:

- Dressing (inability to fasten clothing due to active ROM (AROM), grip and strength deficits)
- Home management (difficulty pushing vacuum cleaner due to wrist and forearm AROM limitations)
- Meal preparation (difficulty grasping utensils and lifting pans due to edema, AROM, and strength problems)

Clinical decision making was of low complexity, as data from the client’s history, profile, and assessments were problem focused and required a review of a limited number of treatment options. No comorbidities affected the current problem, and no modifications were required to complete the assessment.

**Moderate-Complexity Occupational Therapy Evaluation (97166)**

The 68-year-old male presented with a previous amputation below his left knee as well as a recent hospitalization for a...
wound on his right knee and generalized weakness. His past medical history included degenerative joint disease affecting his shoulder, diabetes mellitus, neuropathy, and retinopathy. He lived alone in his own one-level home, which had no structural home modifications, and he received some help from a nearby daughter. He ambulated with a walker and did not use a lower-extremity prosthesis.

The occupational therapist reviewed the occupational profile and the medical and therapy history and observed the client performing desired occupations and activities. The therapist assessed upper extremity (UE) strength, functional mobility, vision, depression, and ADLs. The results showed weakness in shoulder and elbow muscle strength, minimal assistance needed with ADLs and bed-to-chair transfers, and moderate assistance needed to come to standing from the toilet. The client's vision was impaired, resulting in safety issues in ADL and IADL tasks in his home and community. The client experienced significant difficulty in daily activities, including mobility inside the house and in his garden. He also noted that he was having difficulty monitoring and maintaining his glucose levels because of changes in his activity level without modifying his food intake. His low vision also affected his ability to administer insulin appropriately.

Based on the client's occupational profile, history, and assessment results, the occupational therapist developed a plan of care addressing performance deficits in dressing, mobility, and toilet transfers, with potential need for adaptive equipment, visual aids, and home modifications.

The occupational therapist chose the moderate-complexity evaluation code for the following reasons:

- An expanded review of the medical history and profile was required, which included an additional review of physical history given the number of other identified conditions that affected current functional performance.
- Four performance deficits were to be addressed in the plan of care due to the left below knee amputation and the recent infection in the client's right knee.
  - Dressing (limitations due to weakness in shoulder and elbow)
  - Functional mobility (fall risk; difficulty transferring inside and outside of house; vision impairment contributing to safety issues)
  - Toileting and toilet hygiene (difficulty getting on and off the toilet due to UE weakness and functional mobility problems)
  - Health management (visual impairments contributing to difficulty with safe insulin administration; difficulty adjusting insulin levels)
- Clinical decision making was of moderate complexity due to the need to analyze the detailed history, profile, and assessments. Comorbidities (diabetes, retinopathy) were contributing to his activity limitations. The client needed moderate assistance for transfers during the assessment. Several treatment options were considered.

High-Complexity Occupational Therapy Evaluation (97167)

The client was a 29-year-old male who had sustained a head injury with a loss of consciousness while snowboarding 12 weeks earlier. Medical evaluation showed a traumatic brain injury due to a right-sided subdural hematoma. The client underwent a right frontal and temporal craniotomy and other procedures. His medical history included multiple previous concussions during high school, but no prior cognitive problems were noted.

The client was a computer technician, active in many sports, and living independently in an apartment prior to the accident. He indicated some loss of memory, and his accompanying caregiver reported that he was isolating himself from family and friends.

The occupational therapist reviewed the client's occupational profile and the medical and therapy history and observed him performing desired occupations and activities. The therapist performed multiple assessments, including those for ADLs, muscle tone, gross and fine motor coordination, sensory discrimination, and executive function. An interview with the client about his feelings about friends and family revealed significant skill limitations related to active and supportive social relationships. The therapist identified performance problems in ADLs related to left-sided neglect, left UE weakness, decreased touch pressure sensation in his left hand/forearm, and pain. Short-term memory loss, impulsivity, and decreased mental flexibility also were observed. These observations were supported by results of the Executive Function Performance Test (Baum et al., 2008), which also showed multiple deficits in sequencing, initiation of tasks, and safety/judgment, which affected the client's ADLs.

Based on the client's occupational profile, history, and assessment results, the occupational therapist developed a plan of treatment that included addressing performance and safety deficits in ADLs; increasing left side body awareness; pain reduction strategies; and compensatory strategies to improve memory, organizational skills, and daily routines, including improving pursuit of social activity. The therapist discussed safety issues with the caregiver and provided a report for the referring physician that outlined treatment goals, therapy frequency, and duration.

The therapist chose a high-complexity evaluation code for the following reasons:

- An extensive additional review of physical and cognitive history was needed related to current functional performance due to previous concussions identified in the history and profile.
- Five performance deficits were to be addressed in the plan of care due to his head injury:
  - Social participation (isolating behaviors limited socialization; impulsivity and mental rigidity negatively affected social relationships)
Dressing (weakness, sensory deficits and left neglect, and poor sequencing led to difficulty manipulating clothing)

- Home management (lack of initiation of routines affected housekeeping and meal planning; left neglect, memory loss, and diminished organizational skills impacted performance)

- Safety and emergency maintenance (judgment impairment affected all ADLs)

- Health management and maintenance (pain interfered with activity participation, client carry-over of techniques for compensating for memory loss, and initiation strategies)

- Clinical decision making was of high complexity, as it included an analysis of data from a comprehensive history and profile, consideration of the impact of comorbidities (e.g., memory and sensory deficits), and consideration of multiple treatment options. Significant modification was needed to complete assessments due to left-sided neglect and short-term memory loss.

**RE-EVALUATION**

*Re-evaluation:* Reappraisal of the client’s performance and goals to determine the type and amount of change that has taken place. (AOTA, 2014, p. S45)

As with the evaluation codes, a typical time is stated as 30 minutes of face-to-face interaction with the client or family. Again, this is not to be considered a requirement or a limit on time.

Although there are no levels of re-evaluation, the CPT language provides similar guidance for the components of the reevaluation. CPT does not speak to when a re-evaluation can take place; those guidelines are usually provided by payers. Payers such as Medicare and private insurance may have particular rules about when a re-evaluation is reimbursable. The CPT language only describes the items required to bill the code.

**CONCLUSION**

The transition to these new codes may be challenging for therapists and administrators. But the codes are clear in their requirements. The components must be identified and justified in the documentation. Therapists must be clear with administrators that evaluation is a process not defined by the same amount of time or goal. reinsurer and private insurance may have particular rules about when a re-evaluation is reimbursable. The CPT language only describes the items required to bill the code.

To get pricing information and to register to take the exam online for the article New Occupational Therapy Evaluation CPT® Codes: Coding Overview and Guidelines on Code Selection, go to www.aota.org/cea, or call toll-free 877-404-2682.

B. Once registered and payment received, you will receive instant email confirmation with password and access information to take the exam online immediately or at a later time.

C. Answer the questions to the final exam found on page CE-8 by December 31, 2018.

D. On successful completion of the exam (a score of 75% or more), you will immediately receive your printable certificate.

**REFERENCES**


**Final Exam**

**Article Code CEA1216**

New Occupational Therapy Evaluation CPT® Codes: Coding Overview and Guidelines on Code Selection

December 19, 2016

To receive CE credit, exam must be completed by December 31, 2018.

**Learning Level:** Intermediate

**Target Audience:** Occupational therapists and occupational therapy assistants

**Content Focus:** Category 2: OT Process: Evaluation; Category 3: Professional Issues; Coding, Documentation
1. The criteria used for choosing the correct evaluation level:
   A. Must be determined specifically for each of the three components
   B. Must all be at the same level for each component
   C. Must be rated high complexity if the clinical decision making is high
   D. Must reflect the moderate-complexity level if the therapist cannot decide which level to bill

2. The occupational profile contains all but which one of the following components:
   A. The client’s presenting problems and concerns
   B. The client’s desire for treatment techniques and a weekly visit schedule
   C. The client’s priorities for outcomes
   D. The client’s occupational history and experiences, patterns of daily living, interests, values, and needs

3. A key word in CPT® to consider when choosing a level for an occupational profile and medical and therapy history is:
   A. Basic
   B. Informal
   C. Brief
   D. Concise

4. The code descriptors are published annually by the American Medical Association in:
   A. The Journal of the American Medical Association: JAMA CPT® 2017
   C. The Handbook of Insurance Coding: Coding Essentials® 2016

5. The evaluation process and documentation are not intended to:
   A. Communicate occupational therapy’s distinct value to others
   B. Produce a static and sequential intervention plan
   C. Show the breadth of concerns occupational therapy considers
   D. Reflect the clinical work accomplished during the session

6. The choice of a moderate-complexity level in the assessment of occupational performance requires identifying:
   A. One to three performance deficits
   B. Three to five performance deficits
   C. Five or more performance deficits
   D. None of the above

7. The identification of areas of performance deficits is defined in:
   A. The CPT® Manual introductory language to the evaluation codes
   B. Descriptions in the Occupational Therapy Practice Framework: Domain and Process, 3rd Edition
   C. Standards of Practice for Occupational Therapy
   D. Only A and B

8. Clinical decision making:
   A. Is the most important of the three components
   B. Is a critical component in determining the level of the evaluation
   C. Is rated moderate complexity if the data analyzed is from a problem-focused assessment(s)
   D. Is not one of the three components in determining a complexity level

9. Comorbidities are important to document because:
   A. They could affect participation restrictions or activity limitations.
   B. They are identified as affecting client prognosis determinations.
   C. They are the sole factor in choosing a level.
   D. They indicate the need for additional services.

10. The new evaluation codes will go into effect:
    A. January 1, 2017
    B. After a grace period from January 1 to March 1, 2017
    C. July 1, 2017
    D. After the AMA has completed education on the new codes

11. The re-evaluation requirements include:
    A. A re-evaluation completed every 6 months
    B. An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and goals
    C. A formal re-evaluation when there is a documented change in functional status, or a significant change to the plan of care is needed
    D. Only B and C

12. Which one of the following complexity components for clinical decision making should a therapist choose if the evaluation required analysis of data from detailed assessments, consideration of several treatment options, and minimal to moderate modification of the assessments?
    A. Low complexity
    B. Moderate complexity
    C. High complexity
    D. None of the above