Breaking Down the New Evaluation Codes: An Interactive Course
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KPTA Payment Chair

Agenda
- Brief Overview of the New Codes
- FAQs from APTA
- Questions from YOU
- Clinical Scenarios
Learning Objectives

- Identify the new evaluation and reevaluation codes
- Describe the differences between the low complexity, moderate complexity, and high complexity evaluation codes
- Demonstrate knowledge of documentation considerations regarding the new evaluation codes
- Evaluate multiple patient scenarios and select the appropriate evaluation code

The Importance of the Physical Therapist Evaluation

- The evaluation drives the care and/or management of the care.
- A thorough and complete evaluation is critical to success in achieving a positive outcome for the patient's episode of physical therapist care.
- A reflection of the level of complexity of the patient is key to effective management throughout the episode.
Elements of a Physical Therapist Evaluation

Consistent with APTA’s Guide to Physical Therapist Practice

- **Examination** (includes history, systems review, and tests and measures)
- **Evaluation** (the thought process leading to identifying impairments, functional limitations, disabilities, and needs for prevention)
- **Diagnosis** (impact of the condition on function)
- **Prognosis** (professional judgment regarding the predicted functional outcome and the estimated duration of services required)
- **Plan of Care** (the culmination of an evaluation)

2017 Physical Therapy Evaluation Codes

The objective for changes to the evaluation codes:

Facilitate a payment method based on the accurate and complete communication of the following:

- Completed patient assessment instrument
- Evaluation of clinical presentation
- Treatment and management options planned and provided
- Demonstration of value associated with achievement of functional outcomes

Payment Based on Quality and Outcomes = Value to Patient and the Payer
Physical Therapy Evaluation Codes

4 primary elements noted in the code descriptors MUST be documented:
- History
- Examination
- Clinical Decisions Making
- Development of a plan of care

Must communicate information regarding these elements and then decide what level of Evaluation to report

2017 Physical Therapy Evaluation Codes

- 3 Evaluation Codes (97161, 97162, and 97163)
  - Low complexity, moderate complexity, high complexity
  - Components:
    - Patient history (comorbidities, personal factors),
    - Examination and the use of standardized tests and measures,
    - Clinical presentation, and
    - Clinical decision making

- 1 Reevaluation Code (97164)
  - Performed when an established patient is being evaluated to update a plan of care
  - All incorporate use of standardized tests and measures and patient assessment instruments or functional outcome measures
### PT Evaluation 97161 - Low Complexity

<table>
<thead>
<tr>
<th>History</th>
<th>Examination</th>
<th>Presentation</th>
<th>Decision-Making</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No personal factors and/or comorbidities</strong> that impact the plan of care</td>
<td>Of body system(s) using standardized tests and measures addressing 1-2 <strong>elements</strong> from any of the following: body structures and functions, activity limitations, and/or participation restrictions</td>
<td>With <strong>stable and/or uncomplicated characteristics</strong></td>
<td>Clinical decision making of Low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome</td>
</tr>
</tbody>
</table>

### PT Evaluation 97162 - Moderate Complexity

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Present problem with 1-2 <strong>personal factors and/or comorbidities</strong> that impact the plan of care</td>
<td>Of body systems using standardized tests and measures in addressing a total of 3 or more <strong>elements</strong> from any of the following: body structures and functions, activity limitations, and/or participation restrictions</td>
<td>Evolving clinical presentation with <strong>changing characteristics</strong></td>
<td>Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome</td>
</tr>
</tbody>
</table>
### PT Evaluation 97163 - High Complexity

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</thead>
<tbody>
<tr>
<td>Present problem with 3 or more personal factors and/or comorbidities that impact the plan of care</td>
<td>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</td>
<td>With unstable and unpredictable characteristics</td>
<td>Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome</td>
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### PT Re-evaluation 97164

- A single level code
- Applies when there is an established Plan of Care
- Requires an examination including a review of history AND the use of standardized tests and measures
- Describes a revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome
### CPT Code Revisions: “Typical Time”

<table>
<thead>
<tr>
<th>Low Complexity</th>
<th>Moderate Complexity</th>
<th>High Complexity</th>
<th>Reevaluation</th>
</tr>
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<tr>
<td>Typically, 20 minutes are spent face-to-face with the patient and/or family.</td>
<td>Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
<td>Typically, 45 minutes are spent face-to-face with the patient and/or family.</td>
<td>Typically, 20 minutes are spent face-to-face with the patient and/or family.</td>
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### FAQs

**Frequently Asked Questions:**

PT Evaluation Codes
Q: Why were these New Codes Created?

- Needed reform to therapy payment under federal programs
- Increasing regulatory and legislative burdens on PTs spurred APTA to more aggressively pursue alternative payment and coding methods to help ease or prevent policies that negatively affected payment for PT services
- APTA recognized the transition in healthcare from payment for volume of services to value-based services.
- Revising the evaluation codes positions PT as an integral component of new, value-based healthcare.

Q: How Do I Count Personal Factors and Comorbidities?

Contextual Factors that influence how disability is experienced by the individual. Includes:

- Sex, age, coping styles, social background, education, profession, past/current experience
- Overall behavior patterns (fear avoidance, exercise routines)
- Other factors that influence how disability is experienced by the individual
- HOW THIS PERSON'S LIFE MAY IMPACT YOUR PLAN OF CARE
- IF PERSONAL FACTORS THAT EXIST BUT HAVE NO IMPACT ON PLAN OF CARE SHOULD NOT BE CONSIDERED WHEN SELECTING LEVEL OF SERVICE
Patient History

IF IMPACT on PLAN OF CARE: Assists in supporting level of evaluation:

- Comorbidities that impact function and ability to progress through a plan of care
- Previous functional level; context of current functional abilities
- Past treatment approaches, if applicable, and other factors that may impact patient’s ability to progress and reach goals
- Include other contextual factors as applicable
  - Personal factors
  - Environmental factors

Documenting Patient History: Defining Contextual Factors

**Personal Factors** influence how disability is experienced by the individual:

- Include sex, age, coping styles, social background, education, profession, past/current experience
- Overall behavior patterns, learning styles, adherence to interventions

Personal factors that **exist but do not impact** the physical therapy plan of care are not to be considered when selecting a level of service.

**Environmental Factors**

- Physical, social, and attitudinal environment in which people live and experience
Q: How Does One Determine How Many Comorbidities to Count?

- Should only include those that you anticipate will have an impact on your plan of care.
- It is not enough to have a past medical history checklist or to identify comorbidities in a subjective report.
- You MUST establish and specify their impact on the course and/or outcome of treatment.
- Look at disease processes and previous injuries with residual impact.

Q: How does one Determine the Clinical Presentation of the Patient?

- Stable and uncomplicated OR
- Evolving clinical presentation with changing clinical characteristics OR
- Evolving clinical presentation with unstable and unpredictable characteristics
Clinical Presentation

- Typically determined from the patient interview
- Observe the patient’s response to the objective examination (behavior)
- Not only the overall stability of their medical condition but also their functional impairment(s).
- Other factors to consider:
  - Vital sign response
  - Changing levels of pain
  - Varying levels of awareness or cognitive performance
  - Can you complete the exam?
  - Are the findings what you would expect?

Clinical Presentation: Stable

- Uncomplicated, Unchanging, Predictable patient characteristics
- Straightforward problem

1. Patient with centralized low back pain with no muscle weakness, no loss of bladder function, etc.
2. Post-op orthopedic patient whose incision is intact, no drainage present, may or may not have edema, and may or may not have pain. If pain and edema are present, they are consistent and predictable with what you would expect for this condition.
3. Grade 1 ankle sprain with pain and swelling, antalgic gait, however symptoms are predictable and you expect them to progress in a certain manner and timeframe.
Clinical Presentation: Evolving

- Evolving Presentation with Changing Characteristics
- Issues present beyond the area you are evaluating (ex: radicular symptoms)
- Presentation is not exactly what you would expect
- Patient is on weight bearing restrictions or has precautions

1. Patient with centralized low back pain who began to experience radicular symptoms of numbness and tingling into their right foot.
2. A total knee replacement who is having minimal drainage from the incision site and drainage has an odor to it.
3. A stroke patient who was flaccid in her left upper extremity, but now is beginning to get some tone in that arm.
4. A patient who had surgery to repair a fracture. Patient is 8 weeks post-op and the fracture isn't healing as expected (i.e. delayed healing).
5. Patient is NWB on their left L/E for another 2 weeks.
Clinical Presentation: Unstable

- Unpredictable, unstable characteristics
- Could be cognitive deficits or other issues affecting safety

1. Patient with fluctuating heart rate and/or blood pressure
2. Patient with episodes of vertigo of unknown origin and no consistent time frame when it occurs
3. Patient who has variations in their pain level
4. Pain that has no consistency of when it occurs and/or why it occurs
5. Patient with Alzheimer’s who has bursts of anger due to their frustration
6. 7 year-old cerebral palsy patient who has mood swings, low IQ and difficulty maintaining attention and staying focused on a task

Clinical Presentation: Ankle Sprain

- Stable: Pain and swelling in the area of injury, antalgic gait.
- Evolving: Pain beyond the area of injury, atypical signs and symptoms for the diagnosed condition.
- Unstable: Pain in the entire LE, pitting edema which is not resolving, patient becomes lightheaded with attempts at ambulation.
Clinical Presentation: Documentation Considerations

- Clearly document evidence of the patient’s clinical presentation as either stable, evolving, or unstable.
- Include this identification within the assessment portion of the report.
- Evidence of the clinical presentation might include, but is not limited to vital sign response; continuous, intermittent or changing levels of pain; and varying levels of awareness or cognitive performance.

Q: What is the Clinical Decision Making Component?

- Clinical decision making is NOT a separate component; you demonstrate it through effective documentation of your evaluation findings
- Clinical decision making reflects your judgement and multidimensional thinking
- Documentation demonstrating the number of components that you analyze, examine, and coordinate will support the specific level of clinical decision making.
Clinical Decision Making

- To achieve best outcomes the physical therapist uses clinical judgment to determine the overall severity of their complaints/condition and make appropriate decisions regarding interventions to use in treatment based on this patient assessment.
- This clinical judgement occurs at each encounter or session supported as much as possible by current best evidence.

Evaluation complexity: low, moderate, or high

97161, 97162, 97163
Clinical Decision Making: Documentation Considerations

History + physical exam + clinical presentation contribute to decisions reflecting clinical judgment

- To achieve good outcomes, PTs use clinical judgment to determine the overall severity of patients' complaint/condition and make appropriate decisions for interventions based on their patient assessment, at each encounter or session, supported as much as possible by current best evidence.

Impact of Reflecting Complexity in Clinical Decision Making

- Reflect complexity of patient in order to better determine the management path.
- Assessment tools at the front end and outcomes reported at the back end differentiate how patients are managed for potential development of reformed payment model.
- Address variation in care.
Q: Must there be a Functional Outcome Tool used for each Evaluation?

- Standardized patient assessment and/or measurable assessment of functional outcomes are REQUIRED components, and you must include them in your documentation.
- The results of any standardized patient assessment and functional outcomes tools you performed should support your level of clinical decision making.

Q: Do all elements have to be achieved to choose one level over another?

- YES!
- To apply a code at any level of complexity, you must meet the threshold for EACH element, or defer to the lower complexity level.
- “Fire on all 4 cylinders”
- Use the lowest common denominator.
4 Components of Complexity and Severity

- Patient history (medical and functional, including RELEVANT comorbidities and RELEVANT personal factors AND
- Examination AND the use of standardized tests and measures AND
- Clinical presentation of the patient AND
- Clinical decision making (including the use of a standardized patient assessment instrument and/or measurable assessment of functional outcome)

Q: What is an Element, and How Do I Count Elements?

- Body Systems: Body Functions/Structures
- Activity Limitations
- Participation Restrictions

http://apps.who.int/classifications/icfbrowser/
Documenting Examination: Definitions

- Body Regions:
  - Head
  - Neck
  - Back
  - Lower Extremities
  - Upper Extremities
  - Trunk

A Review of Body Systems includes the following:

- Musculoskeletal system: the assessment of gross symmetry, gross range of motion, gross strength, height, and weight
- Neuromuscular system: a general assessment of gross coordinated movement (e.g., balance, gait, locomotion, transfers, and transitions) and motor function (motor control and motor learning)
- Cardiovascular/pulmonary system: the assessment of heart rate, respiratory rate, blood pressure, and edema
- Integumentary system: the assessment of pliability (texture), presence of scar formation, skin color, and skin integrity

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Review of Body Systems also Includes:

- The assessment of the ability to make needs known
- Consciousness
- Orientation (person, place and time)
- Expected emotional/behavioral response
- Learning preferences (learning barriers, education needs)

Documenting Examination: Definitions

**Body Functions**
- Physiological functions of body systems
  - Blood pressure, heart rate, vestibular, sleep
  - Includes psychological functions

**Body Structures**
- Anatomical parts of the body
  - Soft tissue, joint, bone, skin, spinal cord
Documenting Examination: Definitions

**Activity Limitations**
- Difficulties or restrictions experienced by an individual in the execution of a task or action
  - Self care: hygiene, dressing, etc
  - Mobility: changing or maintaining positions, walking, carrying, handling objects, etc
  - Other ADLs: household tasks, assisting others, etc

**Participation Restrictions**
- Difficulties or restrictions experienced by an individual in societal aspects of functioning or in life situations
  - Participating in domestic life
  - Participating as a student or employee
  - Participating as a member of a community
  - Accessing public transportation or other services
How To Count Number of Elements

- Body Functions/Structures (Region)
  - Limitations in the specific Body Function
    - Pain, Loss of ROM, Loss of Strength
- Body Systems Affected
- Activity Limitations
- Participation Restrictions

Documenting Examination:
How To Count Number of Elements

<table>
<thead>
<tr>
<th>Condition</th>
<th>Body Structures/Body Functions</th>
<th>Activity Limitations</th>
<th>Participation Restrictions</th>
<th>Number of Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sprained wrist</td>
<td>Decreased mobility and pain in wrist and hand</td>
<td>Inability to grasp, pick up, or manipulate objects</td>
<td>None</td>
<td>6</td>
</tr>
<tr>
<td>Low back pain</td>
<td>Decreased mobility and pain L-S spine</td>
<td>Difficulty maintaining sitting or standing postures, and lifting over 5 lbs</td>
<td>Unable to perform 50% of work tasks</td>
<td>6</td>
</tr>
</tbody>
</table>
45 year-old right hand dominant female who tore her right rotator cuff 6 weeks when she stumbled going down the stairs and grabbed the handrail to stop herself from falling. Patient had the tear surgically repaired and is now presenting for her physical therapy evaluation. Patient resides at home with her husband and 17 year-old daughter. Patient states she is unable to sleep on her right side and is awakened 2-3 times per night due to her pain. Patient rates her pain as 5/10 at rest and 8/10 when she tries to use her right U/E with activities. Patient states she has limitations and difficulty with washing her hair, brushing and styling her hair, bathing, dressing U/E (donning and doffing bra and sweaters), cooking, and household chores due to pain, limited motion and decreased strength in her right shoulder and arm. Patient states she is only able to lift and carry items weighing a few pounds due to pain and decreased strength.

**Subjective Intake: PMH/PSH:** Negative

- **ROM:** shoulder flexion: 97°, shoulder abduction: 84°, shoulder extension: 11°, shoulder ER: 41°, shoulder IR: 53°
- **Strength:** shoulder flexion: P+, shoulder abduction: P, shoulder extension: P, shoulder ER: P+, shoulder IR: P+
- **Palpation:** Pain with palpation around the incision site and around the shoulder joint complex.
- **Outcome Tool:** Patient was given the DASH to complete. Patient’s disability/symptom score was 56.6%. Highlights of the DASH included the patient rating having severe difficulty with carrying a heavy object, washing or blowing dry her hair, washing her back, putting on a pullover sweater, and placing an object on a shelf above her head. Patient rated moderate difficulty with pushing open a heavy door and preparing a meal.
Body Systems Elements: Documentation Considerations

- It is the therapist’s responsibility to define and defend (through clinical documentation) the specific structure(s) identified for treatment.
- Clearly document any activity limitations and participation restrictions that will be impacted by physical therapy intervention.
- Use standardized tests and measures to objectify the examination findings.
- Identify the combined number of body structures, body functions, activity limitations, and/or participation restrictions as this number is key determinant of the level of complexity.

Q: To Which Providers, Settings and Entities do these New Codes Apply?

- PTs and others providing therapy services in outpatient Part B settings that are billed to third-party payers using CPT codes.
- All HIPAA covered entities must use the updated 2017 CPT codes.
  - Medicare, Medicaid, Cigna, BCBS, United Healthcare, Humana, Tricare etc.

- Worker’s Compensation and No-Fault Auto: HIPAA exempt.
  - Can continue to use old deleted evaluation codes.
  - Contact various plans to see if they will switch to the new codes.
Q: Are the New Evaluation Codes Utilized in Non Part B or Non Outpatient Settings?

- Part A providers are paid based upon DRGs
- In these settings, the new CPT codes are NOT utilized on the claim form
- If an insurance carrier does pay via CPT codes or the patient is switched from inpatient to outpatient status, then the new evaluation and reevaluation codes would apply
- For productivity tracking purposes, many organizations may still use CPT codes

Q: Can I Charge Procedure Codes on the Same Date of Service?

- Neither the CPT handbook nor the NCCI restricts PTs from billing the new evaluation codes on the same day as other therapeutic procedures.
- Many third party payers follow the same regulations
- Billing the new codes along with existing codes may require a 59 modifier to indicate that the procedures are separate and distinct
- Reference the APTA’s NCCI webpage for a resource that lists the affected code pairs
- [http://www.apta.org/payment/medicare/codingbilling/ccil](http://www.apta.org/payment/medicare/codingbilling/ccil)
Q: What Will Payment for the New Evaluation Codes look like in the Future?

- Currently, all 3 new evaluation codes retain the same RVU that the old 97001 code held (1.20).
- The new 97164 Reevaluation code was revalued at 0.75, up from 0.60 value of 97002.
- CMS: Analyze first 5 months of 2017 to determine the percentages billed for each of the evaluation codes.
- APTA hopes CMS proposes different work and practice expense RVUs for the 3 codes in 2018 proposed rule - released July 2017.
- Different work and practice expense RVUs = different payment for the 3 evaluation codes.
- This is why it’s extremely important to code your evaluations accurately and not just code one level of complexity on all of your patient’s since you are being paid the same amount.

Q & A

Aimee Riegel, PT, DPT
Mark Dwyer, PT, MHA, FACHE
Patient Scenarios

Patient Case #1

41 year old female with 3 year history of intermittent LBP, increasing in frequency to daily over the past 2 months. BMI 33, no other co-morbidities. Fluctuating pain from 3-9/10; now 7/10. Oswestry = 35. Works as a day care provider is interrupted at least 1x/week due to LBP. She is unable to stand more than 5 minutes; sleep varies but is impacted 3/5 nights.
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<tbody>
<tr>
<td>1. Symptoms &gt; 6 months</td>
<td>Activity limitations:</td>
<td>Evolving -</td>
<td>MODERATE</td>
</tr>
<tr>
<td>2. BMI &gt; 30</td>
<td>1. Work</td>
<td>Changing Pain</td>
<td>complexity</td>
</tr>
<tr>
<td></td>
<td>2. Standing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Sleeping</td>
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Patient Case #2

14 y/o male 4 days post knee sprain playing basketball; no prior injuries, co-morbidities or significant PMH. Pain is a 4/10, which has decreased from 8/10 at onset. LEFS score is 45. He presents with moderate swelling of the knee, limited ROM, and moderately impaired balance. No deficits with trunk, hip or ankle.

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<tbody>
<tr>
<td>No personal factors or comorbidities</td>
<td>Body Structures: 1. LE 2. Trunk</td>
<td>Stable, pain decreasing</td>
<td>LOW complexity</td>
</tr>
</tbody>
</table>

### Patient Case #3

65 year old male with 6 month history of pain and stiffness of his R shoulder. Currently using NSAIDs and limiting his activities. He has a history of poorly controlled diabetes. He reports dropping objects often, difficulty with dressing and other self care activities. He has limitations with other household chores, scores low on the UEFS.

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Patient Case #4

63 y/o retired M referred to PT for weakness, gait abnormality, hx of R hip fracture. Suffered CVA 7 months ago - R side hemiplegia. While in hospital he fell, fracturing R hip; underwent R hip ORIF. 4 months later - increasing weakness decreasing activity tolerance - limited to short excursions outside of the home. Currently undergoing treatment for colon cancer. PMH: B knee OA, COPD, Diabetes (Type II), hypertension. Requires min-mod A for transfers and ADLs/self care. Gait: FWW, requires CGA/min A for safety/advancing R LE. PLOB: amb with cane, I in ADLs and self care. Sitting/standing balance mod impairment, limited R UE mobility, R LE strength, low O2 sats - SOB upon min exertion. OPTIMAL 75% impaired in moving and walking.

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<tr>
<td>Cancer</td>
<td>Body Regions:</td>
<td>Unstable: low O2</td>
<td>HIGH complexity</td>
</tr>
<tr>
<td>Diabetes</td>
<td>LE/UE/Trunk</td>
<td>Unpredictable: increased</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>Body Systems: Pulmonary</td>
<td>weakness and reduced activity;</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>Mobility</td>
<td>safety risk during gait</td>
<td></td>
</tr>
<tr>
<td>CVA</td>
<td>Self Care</td>
<td></td>
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<td></td>
<td>Participation restrictions</td>
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Patient Case #5

10 y/o F with CP referred to PT for gait, stretching/strengthening. Presents with increasing weakness and muscle hypo extensibility, poor balance and poor endurance. C/o difficulty walking in crowds at school and using playground equipment. Teacher has voiced concerns: safety amb in classroom/halls, falls and inability to negotiate ramp to playground. PLOF: amb I with AFOs and able to play on playground. It has been suggested that she may benefit from a wheelchair in order to allow her to participate in more school activities and to increase her safety, however the parents have been adamant that she will continue to walk and not rely on a chair. Mean PEDI-CAT score is available in chart, significant impairments.

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</table>
| 1. Personal Factors: CP  
2. Environmental factors: Parents  
3. Distance to playground,  
4. Crowded halls/ramp | 1. Muscle weakness  
2. Poor Balance  
3. Poor Endurance  
4. Activity Limitations: walking @ school  
5. Participation restrictions - Recess | Unstable: Increasing weakness and reduced activity tolerance  
Unpredictable: Safety/Falls | HIGH complexity |

### Patient Case #6

18 year old college student, referred to PT for LBP, onset 2 months ago, worsening. He has a PMH of neurofibromatosis. He currently avoids exercising and social/recreational activities for fear of injuring his back. He cannot lift heavy weights, cannot stand more than 10 minutes without pain. He presents with limited spinal mobility, scoliosis, limited core strength/trunk control as well as limited hamstring length. LE strength is 5/5. Oswestry = 38% impaired.

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<tr>
<td>2. Fear avoidance behaviors</td>
<td>2. Avoids recreation/social activities</td>
<td></td>
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<tr>
<td></td>
<td>3. Trunk</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>4. LE</td>
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Patient Case #7

33 y/o female s/p L distal radius fx with 6 weeks in cast. Presents to PT with limited ROM, strength and inability to perform her work as a PT, cannot play guitar, practice yoga and has limitations with self care and performing ADLs. UEFS 51% impaired. Pain is 2/10 at rest – nerve pain/burning in the L thumb with increased pain with activity. PLOF: no deficits. R hand dominant. History of L radial fracture 20 years ago. No comorbidities.

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<tbody>
<tr>
<td>1. Fracture 20 years ago</td>
<td>1. UE deficits</td>
<td>Stable/uncomplicated</td>
<td>LOW complexity</td>
</tr>
<tr>
<td></td>
<td>2. Self care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Work</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Guitar</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Yoga</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>6. ADLs</td>
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**Patient Case #8**

65 y/o male s/p CVA referred for gait and balance exercises. He received 10 days of inpatient rehab then discharged home with his wife 2 days ago. He presents with mild L hemiparesis. Patient reports it is getting easier for him to negotiate the 12 steps to get to the upper level of the house using the right handrail and a step-to gait with just a little help from his wife. He is able to amb with SPC on level surfaces in the house mod I, but requires SBA for community amb and min A on unlevel surfaces such as curbs. PMH/PSH is significant for HTN and atrial fibrillation. Recent test results by his cardiologist indicate that his medication to control the effects of AF will have to be modified.

**Examination:**
- Modified Ashworth scale left upper and lower extremities = 0.
- Coordination tests: 5-second finger-to-nose: R: 5 times; L 3 times; 5 second heel-to-shin: R 5 times; L 3 times.
- Gait speed = 0.8 m/s. Berg Balance Scale = 46/56.
- Dynamic Gait Index = 18/24.

PT goals include improved safety and mobility within community. Independence with amb on even/uneven surfaces and stairs. Independence with performing HEP for strength and coordination of left UE/LE. Improved functional balance and ambulation. Plan of care includes neuromuscular reeducation, gait training, functional training, and therapeutic activities to return the patient to his premorbid level of activity.
Patient Case #8

A 65-year-old male s/p CVA for gait and balance exercises. He received 10 days of inpatient rehabilitation and was discharged home with his wife 2 days ago. He presents with mild left hemiparesis due to a right-sided lesion. The patient is able to ambulate with a straight cane on level surfaces in the house modified independently, but requires close supervision for community ambulation (about 1,000 feet) and minimal assistance on unlevel surfaces such as curbs. PMH/PSH is significant for HTN and atrial fibrillation. Recent test results by his cardiologist indicate that his medication to control the effects of AF will have to be modified. The cardiologist will be contacted to discuss the outcome.

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<tr>
<td>Environmental</td>
<td>Strength</td>
<td>Evolving:</td>
<td>MODERATE</td>
</tr>
<tr>
<td>limitations</td>
<td>Coordination</td>
<td>A-fib/meds</td>
<td>Complexity</td>
</tr>
<tr>
<td>HTN</td>
<td>Balance</td>
<td></td>
<td></td>
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<tr>
<td>A-Fib</td>
<td>Walking</td>
<td></td>
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<tr>
<td></td>
<td>L UE</td>
<td></td>
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<td>L LE</td>
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Patient Case #9

32 yo male computer programmer presents NWB on RLE using crutches. PMHx is significant for ETOH abuse, NIDDM, BMI = 30. 6 months ago fractured his patella playing softball - underwent ORIF right patella. After surgery, spent 6 weeks in long-leg knee immobilizer, NWB. Since surgery, has had moderate right knee pain, has not returned to walking without an AD, not driving. Imaging indicate a mal-union of distal patella. He has not returned to the surgeon for follow up. Meds are the only thing that helps his pain, has been consistently taking Vicodin daily since surgery. He delayed beginning physical therapy until now as “he did not feel ready.”

Examination:
- Right knee ROM 20-90 degrees. He is able to tolerate 30 lbs of weight in static standing on RLE but reports moderate discomfort.
- Pain scale is 5-6/10. LEFS = 35%. FABQW = 35.
- Manual muscle tests of the quadriceps and hamstrings were undetermined due to severe pain.
- Knee (tibial-femoral and patello-femoral) joint accessory motions were restricted.

PT goals were to normalize knee ROM and strength, return patient to work and normal ADLs. Plan of care includes therapeutic exercises, manual therapy, gait training and functional activity training. The PT will coordinate the plan of care with the orthopedic surgeon prior to next visit.
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<tr>
<td>1. NIDDM</td>
<td>1. Strength</td>
<td>Unstable: Prolonged NWB, Malunion Fracture, FABQ indicates unpredictability</td>
<td></td>
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<tr>
<td>2. BMI = 30</td>
<td>2. ROM</td>
<td></td>
<td>HIGH Complexity</td>
</tr>
<tr>
<td>3. Psychosocial Factors:</td>
<td>3. Restricted Accessory</td>
<td></td>
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<tr>
<td>Substance Dependence</td>
<td>Motion</td>
<td></td>
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<td></td>
<td>5. RLE</td>
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Patient Case #10

5-year-old girl presents to the clinic one month s/p percutaneous left heel cord release to facilitate ambulation with heel strike at initial contact rather than walking on her toe on the left. Past medical history is significant for left hemiplegia cerebral palsy. Level 1 - Gross Motor Function Classification System (GMFCS). Prior to surgery, she had zero degrees of passive dorsiflexion. Her mother reported that she was having increasing difficulty in ambulation.

Examination:

- Full passive dorsiflexion on the left but complains of pain with passive stretch to her gastro-soleus muscle.
- Stands independently but does not bear weight on her left foot and maintains the ankle in plantarflexion. Her mother reports that she presently crawls rather than walks around the home.
- AROM of Left ankle: dorsiflexion 6°, plantarflexion 40°. The goal of therapy is for independent ambulation without assistive device.
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<tr>
<td>1. L hemiplegic GP</td>
<td>1. L ankle ROM</td>
<td>Stable</td>
<td>LOW Complexity</td>
</tr>
<tr>
<td>2. GMFCS Level 1</td>
<td>2. Pain</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>3. Decreased WBing</td>
<td></td>
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<td>4. Reduced Mobility</td>
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Patient Case #11

A 70-year-old male office worker presents to physical therapy with low back pain with a VAS pain = 8/10 after working on his garden and taking a long car ride to pick up his granddaughter from college. He also is now experiencing pain in his right posterior leg and lateral foot. Upon evaluation the physical therapist's clinical impression is that the patient's activities of gardening and driving have led to the onset of a new episode of back pain with potential new radicular involvement. PMHx is significant for a recent exacerbation of gout BLE.

Examination:
- Impairments were noted in trunk ROM and muscle strength of the lower quarter
- Neurologic status: myotomes unremarkable. However, sensation to light touch is diminished over the right lateral leg and foot.
- Trunk flexion is markedly limited and is painful. In addition, a lateral shift of the lumbar spine to the left is noted. Trunk extension is limited but repeated trunk extension centralizes his pain
- Oswestry Low Back Pain Disability Questionnaire = 42%

The therapist communicates these findings to the patient's physician and recommends a plan of care for additional physical therapy to manage the symptoms including manual therapy and extension exercises to centralize his complaints of pain.
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<tr>
<td>1. Exacerbation of gout</td>
<td>1. Impaired Trunk ROM</td>
<td>Evolving:</td>
<td>MODERATE</td>
</tr>
<tr>
<td></td>
<td>2. Decreased strength</td>
<td>1. Radicular pain</td>
<td>Complexity</td>
</tr>
<tr>
<td></td>
<td>3. Diminished sensation</td>
<td>2. Consider compensations</td>
<td></td>
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<tr>
<td></td>
<td>4. Oswestry 42%</td>
<td>caused by exacerbation of gout</td>
<td></td>
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Where to Get Additional Education?
- APTA Learning Center
  - Self paced courses with patient vignettes
  - Recorded webinars
- APTA Payment Reform Hub Community and Forum on apta.org (member log in required)
- References at apta.org:
  - www.apta.org/PaymentReform/NewEvalReevalICPTCodes/
- Additional Questions? Send to: advocacy@apta.org
- Utilize the KPTA blog at blog.kpta.com
- Email me at aimee.riegel@ptkansas.com
References

- http://www.apta.org/Payment/Medicare/CodingBilling/FeeSchedule/Summaries/2016/7/15/
- http://www.apta.org/PTinMotion/News/2016/9/7/FeeSchedule/
- Elliott, Carmen MS. New CPT Evaluation Codes Are Here. PT in Motion: February 2017.