Documenting Physical Therapy

Understanding Medicare Expectations

Missouri Physical Therapy association
2017 Fall Conference- Oct 14, 2017
Objectives

1. The therapist will understand CMS requirements for documentation of evaluations, re-evaluations, progress reports, and daily documentation of services.
2. The learner will understand reasons for CMS payment denial based on documentation.
3. The learner will have tools for including CMS “skilled” terminology in their documentation.
“Either write something worth reading or do something worth writing.”

Benjamin Franklin
Prevention

- The key to preventing denials is documentation of skilled services that were provided.
- The key to documenting skilled services is understanding the Medicare requirements for coverage.
- The key to understanding why the services provided are skilled is understanding the reasoning behind the services provided.
Skilled Care Determinates

Claims for skilled care coverage need to include sufficient documentation to enable a reviewer to determine whether—

• Skilled involvement is required in order for the services in question to be furnished safely and effectively; and

• The services themselves are, in fact, reasonable and necessary for the treatment of a patient’s illness or injury, i.e., are consistent with the nature and severity of the individual’s illness or injury, the individual’s particular medical needs, and accepted standards of medical practice. The documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.

Medicare Benefit Policy Manual – Chapter 8  30.2.2.1
Reasonable and Necessary

Skilled Therapy services must meet all of the following conditions;

- Care must be related to an active and written plan of care by a qualified therapist.
- Services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge and skills of a qualified therapist.
Reasonable and Necessary

Skilled Therapy services must meet all of the following conditions:

- Services must be provided with the expectation that the condition of the patient will improve in a reasonable and generally predictable period of time; or the services must be necessary to establish a safe and effective maintenance program; or the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program.

- Services must be considered under accepted standards of practice to be specific and effective for the patient’s condition

- Services must be reasonable and necessary.
Skilled Services

- Paint a picture of the patient’s impairments and functional limitations requiring skilled intervention;
- Describe the prior functional level to assist in establishing the patient’s potential and prognosis;
- Describe the skilled nature of the therapy treatment provided;
- Justify that the type, frequency and duration of therapy is medically necessary for the individual patient’s condition;
- Clearly document both Timed Code Treatment Minutes and Total Treatment Time in order to justify the units billed;
- Identify each specific skilled intervention/modality provided to justify coding.
Initial Plan of Care

- Presenting condition or complaint...."What brings the patient to therapy at this time?"
  - Patients should exhibit a significant change from their “usual” physical or functional ability to warrant an evaluation.
  - Provide an objective description of the changes in function that now necessitate skilled therapy. Simply stating “decline in function” does not adequately justify the initiation of therapy services.

  “Patient has exacerbation of arthritis that resulted in increased pain and decrease strength caused a decline in balance, with increased difficulty with gait, transfers and bed mobility”
Initial Plan of Care

- Diagnosis and description of specific problem(s) to be evaluated
  - Medical Condition that caused the treatment are used; complicating conditions are used in non-primary positions
  - The diagnosis should be specific and as relevant to the problem being treated as possible. In many cases, both a medical diagnosis (obtained from the physician/NPP) and an impairment-based treatment diagnosis are relevant.
  - Include area of the body, and conditions and complexities that could impact treatment
  - Date of onset
Initial Plan of Care

- Relevant medical history
  - Applicable medical history, medications, co-morbidities (factors that make therapy more complicated or require extra precautions)
- Prior diagnostic imaging/testing results
- Prior therapy history for the same diagnosis, illness or injury
  - If recent therapy was provided, documentation must clearly establish that additional therapy is reasonable and necessary
Initial Plan of Care

- Complicating Factors
  - Describe how and why they affect the treatment
    - Cardiac dysrhythmia is not a condition for which a therapist would directly treat a patient, but in some patients such dysrhythmias may so directly and significantly affect the pace of progress in treatment for other conditions. Documentation should indicate how the progress was affected by the complexity. Or, the severity of the patient’s condition as reported on a functional measurement tool maybe so great as to suggest extended treatment is anticipated
Initial Plan of Care

• Social support/environment
  • Does the patient live alone, with a caregiver, in a group home, in a residential care facility, in a skilled nursing facility (SNF), etc.?
    • What level of support is available, and what level of independence is required for the patient to be safe in the home environment?
  • Does the home situation have obstacles that the patient must overcome (e.g., stairs without handrails)?
  • What are the patient’s usual responsibilities in the home environment?
Initial Plan of Care

- Prior level of function
  - Key piece of information used for establishing potential, prognosis and realistic functional goals
  - Functional status just prior to the onset of the treating condition requiring therapy
  - Record in objective, measurable and functional terms
  - Establishes baseline to support the Medical Necessity
Initial Plan of Care

- Functional testing
  - Objectively measure and/or describe the patient’s current level of functioning. Examples, based on the patient’s need, may include:
    - mobility status (transfers, bed mobility, gait, etc.);
    - self-care dependence (toileting, dressing, grooming, etc.);
    - meaningful ADLs/IADLs;
    - pain, and how it limits function; and
    - functional balance
  - Description of quality of functional movement
    - Gait deficits, substitution(s), etc.
Initial Plan of Care

- **Objective impairment testing**
  - Testing done to determine the source or cause of the functional limitation(s), such as ROM, manual muscle testing, coordination, tone assessment, balance etc.
  - Use concise, objective measurements. Avoid minimal/moderate/severe types of descriptions when more specific definitions or measurements are available. For example, when measuring shoulder flexion AROM, document degrees of motion, rather than documenting, “Shoulder flexion: minimal loss of motion.”
Standardized Testing

- Required to indicate objective, measurable beneficiary physical function
  - Functional assessment individual item and summary scores from commercially available therapy outcomes instrument
  - Functional assessment scores from tests and measurements validated in the professional literature that are appropriate for the condition/function being measured
Initial Plan of Care

Assessment

Summary of the therapist’s analysis of the condition being evaluated including clinical judgments and subjective impressions based on the current functional status. Clinical reasoning for treatment should be evident when further therapy is recommended.

“Patient requires increased assistance with transfers and bed mobility due to decline in strength in Quads, hamstrings, and anterior tibs. Patient has decrease in balance with decline in righting reactions and stepping strategies.”
Initial Plan of Care

- Treatment Modalities, procedures, or interventions to be provided
  - Where not specified, one treatment session per day is assumed. If more than one session per day is provided additional documentation to support the amount of therapy.

- Frequency of Treatment

- Duration of Treatment

- Prognosis for return to prior functional status or maximum expected condition within expected time frame and plan of care.

- Signature and credentials of therapist and physician/NPP and date.
Evaluation

- Short Term Goals
  - Pertain to the underlying impairment that impact functional impairment findings documented in the evaluation
  - Stepping stones to the functionally based goals outlined in the Long Term Goals
Initial Plan of Care

- **Long Term Goals**
  - pertain to the functional impairment findings documented in the evaluation;
  - reflect the final level the patient is expected to achieve as a result of therapy in the current setting;
  - be realistic, and should have a positive effect on the quality of the patient’s everyday functions;
  - be function-based and written in objective, measurable terms with a predicted date for achieving the goals.
## Evaluation Codes

<table>
<thead>
<tr>
<th></th>
<th>CPT 97161-Low</th>
<th>CPT 97162-Moderate</th>
<th>CPT 97163- High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration</strong></td>
<td>Typically 20 minutes face to face</td>
<td>Typically 30 minutes face to face</td>
<td>Typically 45 minutes face to face</td>
</tr>
<tr>
<td><strong>History</strong></td>
<td>Patient has a history of the present problem without any personal factors and/or comorbidities that impact the plan of care</td>
<td>Patient has a history of the present problem with a history of 1-2 personal factors and/or comorbidities that impact the plan of care</td>
<td>Patient has a history of the present problem with a history of 3 or more personal factors and/or comorbidities that impact the plan of care</td>
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<td><strong>Examination</strong></td>
<td>Examination of body system(s) completed using standardized tests/measures for 1-2 elements from: body structures and functions, activity limitations, and/or participating restrictions</td>
<td>Examination of body system(s) completed using standardized tests/measures for 3 or more elements from: body structures and functions, activity limitations, and/or participating restrictions</td>
<td>Examination of body system(s) completed using standardized tests/measures for 4 or more elements from: body structures and functions, activity limitations, and/or participating restrictions</td>
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<td><strong>Clinical Presentation</strong></td>
<td>Clinical presentation is stable and/or uncomplicated</td>
<td>Clinical presentation is evolving with changing characteristics</td>
<td>Clinical presentation is unstable with unpredictable characteristics</td>
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Re-evaluation

- Re-evaluation
  - Not a routine recurring service
  - Clear justification for the need for further test and measurements after the initial evaluation
    - New clinical findings
    - Significant unanticipated change in the patient’s condition
    - Failure to respond to the interventions in the initial Plan of Care
- Must contain all the applicable components of the initial evaluation.
  - New or ongoing problems may need to be re-evaluated
Progress Reports

- Progress Reports provide justification for the Medical Necessity of treatment
  - Progress reports shall be written by the therapist who provides the services and supervises an assistant or the physician/NPP who provides or supervises the services.
  - Date of the beginning and end of the reporting period that this report refers to, the end of the progress report period is either a date chosen by the clinician or the 10th treatment day, whichever is shorter.
  - Date the report was written or dictated
  - Objective reports of the patient’s subjective statements, if they are relevant. For example, “Patient reports pain after 20 repetitions”. Or, “The patient was not feeling well on 11/05/06 and refused to complete the treatment session.”
Progress Reports

- Assessment of improvement, extent of progress (or lack thereof) toward each goal;
  - Description of changes in status relative to each goal currently being addressed in treatment. Descriptions shall make identifiable reference to the goals in the current plan of care;
  - Revisions of goals based on assessment(s) and progress (or lack thereof)
- Objective measurements (impairment/function testing) to quantify progress and support justification for continued treatment;
  - Objective evidence consists of standardized patient assessment, outcome measurements tools or measurable assessments of functional outcome. Quantifies the progress and supports justification for continued treatment.
Progress Reports

- Plans for continuing treatment, including documentation of treatment plan revisions appropriate;
  - Clinical Reasoning for treatment plan revisions
- Clinical Justification to continue therapy
  - Skilled services provided over reporting period
  - Education provided
    - What, Who and response to the education provided.
- Signature with credentials of the clinician who wrote the report.
Certifications/Recertifications

Medicare beneficiaries receiving outpatient (Med B) services must be under the care of a Physician/NPP. Orders and certifications/recertifications are common means of demonstrating such evidence of physician involvement.

- Certification requires dated Physician/NPP signature on the therapy plan of care or a document that indicates approval of the plan of care.
- Certification must contain all the required elements of a plan of care.
Certification/Recertification

Certifications/Recertifications should include the following elements:

- The date from which the plan of care being sent for certification becomes effective (for initial certifications, the initial evaluation date will be assumed to be the start date of the certified plan of care);
- Diagnoses;
- Long term treatment goals;
- Type, amount, duration and frequency of therapy services;
- Signature, date and professional identity of the therapist who established the plan; and
- Dated physician/NPP signature indicating that the therapy service is or was in progress and the physician/NPP makes no record of disagreement with the plan. (Note: The CORF benefit does not recognize an NPP for certification.)
Functional Reporting

- Functional G codes are used in identifying the functional limitations being reported.
  - Six of the G-code sets are generally for PT
  - Only 1 functional limitation shall be reported at a time.
    - Select the G code set for the functional limitation that most closely relates to the primary functional limitation being treated or the one that is the primary reason for treatment
    - When more than one functional limitation the supervising therapist may need to make a determination as to which is primary.
      - Most clinically relevant to a successful outcome
      - One that would yield the quickest and/or greatest functional progress
      - The one that has the greatest priority for the patient
Functional Reporting

When one of the four PT categorical code sets do not describe the patient’s functional limitation the supervising therapist reports one of the “Other PT“ functional G-code sets.

- A patient whose therapy services are not intended to treat a functional limitation; or
- A patient’s functional limitation where an overall, composite, or other score from a functional assessment tool is used and does not clearly represent a functional limitation defined by one of the above four categorical PT code sets.
- The subsequent “Other PT/OT” G-code set is only reported after the primary “Other PT/OT” G-code set has been reported for the beneficiary during the same episode of care.
Functional Reporting

Each G-code requires a severity modifier. The modifiers are used to convey the severity of the functional limitation: current status, the goal status, and the discharge status. The severity modifier reflects the patient's percentage of functional impairment for each functional status: current, goal and discharge.

- Documentation supporting the decision of the G-codes and the severity modifiers must be part of the Medical Record.
Functional Reporting

In selecting the severity modifier the supervising therapist:

- Uses the severity modifier that reflects the score from a functional assessment tool or other performance measurement instrument, as appropriate.
- Uses his/her clinical judgment to combine the results of multiple measurement tools used during the evaluative process to inform clinical decision making to determine a functional limitation percentage.
- Uses his/her clinical judgment in the assignment of the appropriate modifier.
- Uses the CH modifier to reflect a zero percent impairment when the therapy services being furnished are not intended to treat (or address) a functional limitation.
Assistance’s Progress Reports or Interim Notes

- PTA’s may write elements of the progress report dated between therapist progress reports and are part of the Medical Record.
  - Date that the report was written
  - Signature, and professional identification who wrote /dictated the report and the date it was done.
  - Objective reports of the patient’s subjective statements, if they are relevant
  - Description of changes in status relative to each goal currently being addressed in treatment, if they occur. Note that assistants may not make clinical judgments about why progress was or was not made, but may report the progress objectively.
Daily Treatment Notes

- Purpose of these notes is simply to create a record of all treatments and skilled interventions that are provided and record the time of the services in order to justify the use of the billing codes on the claim.

- Treatment note is required to document the medical necessity or appropriateness of the ongoing therapy services.
  - Date of treatment
  - Description of skilled interventions should be included
  - Identification of each specific intervention/modality provided and billed, for both timed and untimed codes, in language that can be compared with the billing on the claim to verify correct coding.

- Change in treatment under direction of supervising therapist must be recorded and justified on the medical record and either in the treatment note or the progress report. New exercises added or changes made help to justify that the services are skilled.
Daily Treatment Notes

- May include any information that is relevant in supporting the medical necessity and skilled service
  - patient comments regarding pain, function, completion of self management/home exercise program (HEP), etc.;
  - significant improvement or adverse reaction to treatment;
  - significant, unusual or unexpected changes in clinical status;
  - parameters of modalities provided and/or specifics regarding exercises such as sets, repetitions, weight;
Daily Treatment Notes

• description of the skilled components of the specific exercises, training, or activities;
• instructions given for HEP, restorative or self/caregiver managed program, including updates and revisions;
• communication/consultation with other providers (e.g., supervising clinician, attending physician, nurse, another therapist);
• communication with patient, family, caregiver;
• equipment provided
• any additional relevant information to support that the patient continues to require skilled therapy and that the unique skills of a therapist were provided.
Daily Treatments Notes

If grid or checklist forms used for daily notes

• Include signature logs and credentials
• Document skilled components of exercises so that they do not appear repetitive and therefore unskilled.
• Document functional activities performed and the skilled components/techniques of the qualified professional personnel used to improve the functional activity
97110- Therapeutic Exercise

Many therapeutic exercises may require the unique skills of a therapist to evaluate the patient’s abilities, design the program, and instruct the patient or caregiver in safe completion of the special technique. However, after the teaching has been successfully completed, repetition of the exercise, and monitoring for the completion of the task, in the absence of additional skilled care, is non-covered.

- Objective measurements of loss of strength and range of motion (with comparison to the uninvolved side) and effect on function.
- If used for pain include pain rating, location of pain, effect of pain on function. Specific exercises performed, purpose of exercises as related to function, instructions given, and/or assistance needed to perform exercises to demonstrate that the skills of a therapist were required.
- When skilled cardiopulmonary monitoring is required, include documentation of pulse oximetry, heart rate, blood pressure, perceived exertion, etc.
- Documentation should describe new exercises added, or changes to the exercise program to help justify the services as skilled.
97112-Neuromuscular Re-education

This therapeutic procedure is provided for the purpose of restoring balance, coordination, kinesthetic sense, posture, and proprioception (PNF, vestibular rehab, balance and posture training).

- This procedure may be reasonable and necessary for restoring prior function which has been affected by:
  - loss of deep tendon reflexes and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers;
  - nerve palsy, such as peroneal nerve injury causing foot drop;
  - muscular weakness or flaccidity as result of a cerebral dysfunction, a nerve injury or disease or having had a spinal cord disease or trauma;
  - poor static or dynamic sitting/standing balance;
  - postural abnormalities;
  - loss of gross and fine motor coordination;
  - hypo/hypertonicity.
When therapy is instituted because there is a history of falls or a falls screening has identified a significant risk for falls documentation should indicate:

- specific fall dates and/or hospitalization(s) and reason for the fall(s), if known;
- most recent prior functional level of mobility, including assistive device, level of assist, frequency of falls or “near-falls”;
- cognitive status;
- prior therapy intervention;
- functional loss due to the recent change in condition;
- balance assessments (preferably standardized), lower extremity ROM and muscle strength testing;
- patient and caregiver training;
- carry-over of therapy techniques to objectively document progress.
Supportive Documentation for 97112:

- **Objective loss of activities of daily living (ADLs), mobility, balance, coordination deficits, hypo- and hypertonicity, posture and effect on function.** ADL means basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

- **Specific exercises/activities performed (including progression of the activity), purpose of the exercises as related to function, instruction given, and/or assistance needed, to support that the skills of a therapist were required.**
97116- Gait Training

- Objective measurements of balance and gait distance, assistive device used, amount of assistance required, gait deviations and limitations being addressed, use of orthotic or prosthesis, need for and description of verbal cueing
- Presence of complicating factors (pain, balance deficits, gait deficits, stairs, architectural or safety concerns)
- Specific gait training techniques used, instructions given, and/or assistance needed, and the patient’s response to the intervention, to demonstrate that the skills of a therapist were required
In order for therapeutic activities to be covered, the following requirements must be met:

- the patient has a documented condition for which therapeutic activities can reasonably be expected to restore or improve functioning;
- there is a clear correlation between the type of therapeutic activity performed and the patient’s underlying medical condition;
- the patient’s condition is such that he/she is unable to perform the therapeutic activities without the skilled intervention of the qualified professional/auxiliary personnel.
Supportive Documentation Requirements

- Objective measurements of loss of ADLs, balance, strength, coordination, range of motion, mobility and effect on function
- Specific activities performed, and amount and type of assistance to demonstrate that the skills and expertise of the therapist were required
Supportive Documentation Requirements:

- Area(s) being treated
- Soft tissue or joint mobilization technique used
- Objective and subjective measurements of areas treated (may include ROM, capsular end feel, pain descriptions and ratings,) and effect on function
For MLD/CDP, supportive documentation should include:

- medical history related to onset, exacerbation and etiology of the lymphedema
- comorbidities
- prior treatment
- cognitive and physical ability of patient and/or caregiver to follow self-management techniques;
- pain/discomfort descriptions and ratings;
- limitation of function related to self-care, mobility, ADLs and/or safety;
- prior level of function;
- limb measurements of affected and unaffected limbs at start of care and periodically throughout treatment;
- description of skin condition, wounds, infected sites, scars
Group Therapy

Group therapy consists of therapy treatment provided simultaneously to two or more patients who may or may not be doing the same activities. If the therapist is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time, one unit of CPT code 97150 is appropriate per patient.

- The purpose of the group and the number of participants in the group
- Description of the skilled activity provided in the group setting, such as instruction in proper form, or upgrading the difficulty of the activity for an individual.
Co-Treatment

Co-treatment may be appropriate when practitioners from different professional disciplines can effectively address their treatment goals while the patient is engaged in a single therapy session. For example, a patient may address cognitive goals for sequencing as part of a speech-language pathology (SLP) treatment session while the physical therapist (PT) is training the patient to use a wheelchair, or a patient may address ADL goals for increasing independence as part of an occupational therapist (OT) treatment session while the PT addresses balance retraining with the patient to increase independence with mobility.
Co-Treatment

- Co-treatment is appropriate when coordination between the two disciplines will benefit the patient, not simply for scheduling convenience.
- Documentation should clearly indicate the rationale for co-treatment and state the goals that will be addressed through this method of intervention.
- Co-treatment sessions should be documented as such by each practitioner, stating which goals were addressed and the progress made.
- Co-treatment should be limited to two disciplines providing interventions during one treatment session.
Discharge Notes

Discharge note is required for each episode of treatment and must be written by the supervising therapist.

- Discharge note is a progress report covering the time from the last progress report up to the date of the discharge and includes all required components of a progress report.

- Discharge note is the last opportunity to justify the medical necessity of the entire treatment episode.
  - Discuss the skilled services provided over the episode of treatment; including education and response.
  - Progress made to from beginning of episode of care to day of discharge.
  - Include discharge destination
Maintenance Therapy

Maintenance therapy occurs when the skills of a therapist (as defined by the scope of practice for therapists in each state) are necessary to safely and effectively furnish a recognized therapy service, whose goal is to maintain functional status or to prevent or slow further deterioration in functional status.

- If the specialized skill, knowledge and judgment of a qualified therapist are required to establish or design a maintenance program to maintain the patient’s current condition or to prevent or slow further deterioration, the establishment or design of a maintenance program by a qualified therapist is covered.
Maintenance Therapy

- If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the maintenance program, such instruction is covered.
- If skilled therapy services are needed for periodic reevaluations or reassessments of the maintenance program, such periodic reevaluations or reassessments are covered. Such skilled care is necessary for the performance of a safe and effective maintenance program only when:
  - (a) the therapy procedures required to maintain the patient’s current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to furnish the therapy procedure or
  - (b) the particular patient’s special medical complications require the skills of a qualified therapist to furnish a therapy service required to maintain the patient’s current function or to prevent or slow further deterioration, even if the skills of a therapist are not ordinarily needed to perform such therapy procedures.
Maintenance Therapy

Jimmo vs Sebalias

- Once a maintenance program is established, coverage of therapy services to carry out a maintenance program turns on the beneficiary's need for skilled care. A maintenance program can generally be performed by the beneficiary alone or with the assistance of a family member, caregiver or unskilled personnel. In such situations, coverage is not provided. However, skilled therapy services are covered when an individualized assessment of the patient’s clinical condition demonstrates that the specialized judgment knowledge, and skills of a qualified therapist are necessary for the performance of safe and effective services in a maintenance program.

- While a beneficiary’s particular medical condition is a valid factor in deciding if skilled (rehabilitative or maintenance) therapy services are needed, a beneficiary’s diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a qualified therapist are needed to treat the illness or injury, or whether the service(s) can be carried out by non-skilled personnel.

- If at any point in the treatment it is determined that the treatment becomes repetitive and does not require the unique skills of a therapist, the services are non-covered.
Non skilled Services

- Assistance in dressing, eating, and going to the toilet
  - If the patient can with or without the assistance of an aide or other caregiver do activities planned by a clinician, without the active participation of the qualified professional they are considered unskilled.
- Periodic turning and positioning in bed;
- General supervision of exercises, which have been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance
  - If at any point the treatment is determined to become repetitive and does not require the skills of a therapist the service is not covered
- Routine care in connection with braces and similar devices;
- Use of heat as a palliative and comfort measure, such as whirlpool or steam pack;
Thoughts

- Patient Center Care
- Document the Care you Provide
- Document the Clinical Reasoning for the decisions you make
- Value your skills
- Get Back to Basics
• Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services; Revision 235, 7-11-2017
• Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance; Revision 228, 10-13-2016
• Medical Policy Center - NCD for Outpatient Physical and Occupational Therapy Services (L33631); updated 1-01-2017
• https://www.apta.org/uploadedFiles/APTAorg/Payment/Medicare/Coding_and_Billing/SNF/JointCotreatmentGuidelinesUnderMedicare_ASHAAOTAAPTA.pdf