

Technical Criteria for Reviewing
Ancillary Services for Adults

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Technical Criteria for Reviewing Ancillary Services for Adults

I. PHYSICAL THERAPY: REVIEW FOR BILLING AS ANCILLARY

- A. **STANDARDS OF PRACTICE:** The review process shall employ the standards of practice developed by the American Physical Therapy Association.
- B. Deficiency of function must be of a significant level that an ancillary clinician's expertise in designing or conducting a program in the presence of potential gain is documentable.
1. Therapeutic exercise
 - a. When exercising muscle or joint structure, the deficit requires a therapist's expertise to design, supervise, or conduct a program in which there is a need for functional or performance gain.
 - b. Progress is shown at predictable intervals.
 - c. Gradual progression is from passive to fully active range of motion per situation and reasonable goal.

Indication for Denial

- a. Lacks documented detail of dysfunction or goal.
- b. Goal seems unreasonable.
- c. Stability of resident questioned.
- d. Participation level a hindrance.
- e. Plateaued, goal achieved, or needs only repetitive range of motion for nursing care plan.
- f. Persistent flaccidity > 2—4 weeks in the focused area.

2. Cold Therapy

- a. Pain or spasm reduction or adjustment to range of motion exercise (repeated cycles).
- b. Trigger point use myofascial pain syndrome.
- c. Spasticity.

Indication for Denial

- a. Response gain is not demonstrable.
- b. Performance is at nursing instructed level, and labile complex features.
- c. Inappropriate use in a vascular compromised setting (or labile or poor blood pressure control).
- d. Cold sensitivity disorder.

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3. Low—Energy Laser

- a. Wound tissue healing.
- b. Pain management over trigger points.

Indication for Denial

- a. Investigational.
- b. Effectiveness in rheumatoid arthritis questioned.

4. Transcutaneous Electric Nerve Stimulation (TENS)

- a. Post—operative incisional pain.
- b. Orthopedic analgesia acute or chronic, application to either trigger point or peripheral nerve.
- c. Chronic low back pain.
- d. Osteogenesis.
- e. Reflex sympathetic dystrophy (RSD).

Indication for Denial

- a. Chronic radiculopathy pain.
- b. Cognitively impaired or unwilling to participate with schedule and safety factors.
- c. Unsafe application.
- d. Nursing is capable of managing (or resident can set—up, apply or control) after the initial evaluation of response or control setting is achieved.

5. Heat Therapy

- a. Active treatment of musculoskeletal mobility or pain problem as part of a therapist—driven treatment plan.
- b. In conjunction with an exercise regimen.

Indication for Denial

- a. The active disorder is controlled, mostly for comfort.
- b. Complexity manageable by nursing.
- c. Resident is not responsive or is non-communicative.
- d. Ischemic limbs or other site or atrophic skin.

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6. Ultrasound

- a. Joint contracture or scar tissue before friction massage, stretch, or range of motion (ROM) exercise (intensities and durations still need work), i.e., post—hip open reduction internal fixation.
- b. Reduce pain or muscle spasm.
- c. Trigger points.

Indication for Denial

- a. Use in precautionary situations.
- b. Impaired sensitivity or ischemia.
- c. Questionable efficacy such as chronic herpes zoster, hemiplegic shoulder pain, fresh wound, or chronic pressure sore.

7. Hydrotherapy

- a. Facilitate assistive or resistive exercise.
- b. Removal of exudated or necrotic tissue.
- c. Reduce muscle spasm or pain.

Indication for Denial

- a. General heat precautions.
- b. Treatment exposure using > 37 degrees centigrade in vascular impaired site.
- c. Absence of untoward effects or stable temperature tolerance and can be done by nursing staff.

8. Iontophoresis

- a. Antibiotic institution to avascular tissue.
- b. Medication for persistent post—surgical incision pain.
- c. Reduce inflammation or edema of musculoskeletal (joints).

Indication for Denial

- a. Anesthetic use (injection faster).
- b. Response lacking after reasonable interval.

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9. Prosthesis

- a. Candidate has the capacity to use device.
- b. Candidate shows muscular strength, motor control, and range of motion adequate for gainful use.

Indication for Denial

- a. Unteachable.
- b. Lacks items in 9-a and b.
- c. Poor wound healing.
- d. Other inappropriate conditions (such as bilateral, above-knee amputation over age 45, or below-elbow amputee or flail joint shoulder or elbow).
- e. Repetitive exercises that nursing care plan can accomplish pre—prosthesis for stump shrinker use or prosthetic fitting.
- f. Repetitive use for distance or endurance only with level change having been achieved.
- g. Assisting routine care of equipment.
- h. Safety has been established so that the resident can perform trained exercise with supervision by nursing being the only need.

10. Electromyographic Biofeedback

- a. Spasticity or weakness as part of an acute cerebral vascular accident (CVA).
- b. Acute or chronic spinal cord injury.
- c. Multiple sclerosis with mild spasticity.

Indication for Denial

- a. Absence of reasonable gain in the treatment plan time frame.
- b. Questionable effectiveness for the condition.
- c. Resident lacks voluntary control or motivation.

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11. High Pressure Wound Irrigation

- a. Heavily contaminated wounds.

Indication for Denial

- a. Clean proliferating wounds.
- b. Equipment or devices of questionable effectiveness or superiority to simpler devices.
- c. Nursing can provide equivalent service.

12. Hyperbaric Oxygen Wound Care

- a. Infected wounds or decubitus.
- b. Has reasonable circulation.

Indication for Denial

- a. Advanced ischemic area.
- b. Potential for thromboembolism.
- c. Severe vasospasm.
- d. Lack of significant improvement in 4 weeks.

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II. OCCUPATIONAL THERAPY: REVIEW FOR BILLING AS ANCILLARY

- A. **STANDARDS OF PRACTICE:** The review process shall employ the standards of practice developed by the American Occupational Therapy Association.
- B. Deficiency of function must be of a significant level that an ancillary clinician's expertise in designing or conducting a program in the presence of potential gain is documentable.

1. Therapeutic exercise

- a. When exercising muscle or joint structure the deficit requires a therapist's expertise to design, supervise, or conduct a program in which there is a need for functional or performance gain.
- b. Progress is shown at predictable intervals.
- c. Gradual progression is from passive to fully active range of motion per situation and reasonable goal.

Indication for Denial

- a. Lacks documented detail of dysfunction or goal.
- b. Goal seems unreasonable.
- c. Stability of the resident questioned.
- d. Participation level is a hinderance.
- e. Plateaued, goal achieved, or needs only repetitive ROM for nursing care plan.
- f. Persistent flaccidity > 2—4 weeks focused area.

2. Shared Modalities for Physical Therapy

- a. Heat therapy.
- b. Cold therapy.
- c. Prosthesis.
- d. Electromyographic biofeedback.

Indication for Denial (see listings for Physical Therapy)

3. Functional Activities of Daily Living

- a. Feed.
- b. Dress.
- c. Bathe.
- d. Toileting.
- e. Grooming.

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f. Cognition.

Indication for Denial

- a. The condition prevents the individual from engaging in the technique or use of the device.
- b. Technique is reached, resident or nursing staff can maintain activities for endurance, distance or repetition.
- c. Chronic condition, therefore potential useful gain is questioned or minimal.
- d. Unable to advance or use more complex dexterity level due to cognitive limits..
- e. Biofeedback use in the presence of a prominent disorder. speech, language use, cognition or volitional ability (inability to follow festural or verbal instruction.
- f. Coma stimulation - effectiveness questionable

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III. SPEECH THERAPY: REVIEW FOR BILLING AS ANCILLARY

- A. **STANDARDS OF PRACTICE:** The review process will employ the preferred practice patterns developed by the American Speech—Language—Hearing Association.
- B. Deficiency of function must be of a significant level that an ancillary clinician's expertise in designing or conducting a program in the presence of potential gain is documentable.
 - 1. Treatment of Dysphagia (swallowing) Disorders
 - a. Applicable diagnostic tests with confirmed abnormality (initial or progress recheck).
 - b. Active teaching is appropriate for cognitive level (vs. delay till progress gain and provides alternative nutrition source).
 - c. Uses specific postural, reflex facilitation, food placement, modified diet techniques with demonstrable progress.
 - d. Prosthetic use.

Indication for Denial

- a. Plateau, learned response, and repetitive exercise, reminders or prosthetics can be done by nursing as effectively.
 - b. Confirmatory diagnostic test unavailable.
 - c. Resident uncooperative or unreliable to safely use needed techniques.
- 2. Speech and Cognitive Disorders
 - a. Tentative projected rehabilitation gain at the stage when cognitive level permits measurable change.
 - b. Participation by resident required for repetitive or grouped exercises.
 - c. Prosthetic training.
 - d. Demonstrates there is no contributing significant auditory impairment.
 - e. Use of nursing facility environment or staff to assist goals.

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Indication for Denial

- a. Inability to participate.
- b. Plateau is reached in functional gain by measurable data or learned exercise and nursing can do repetitive technique.
- c. Effectiveness of modality or participation level is in question.
- d. Persisting active program beyond gain in condition having progressive deteriorating change or outlook (bilateral cerebral vascular accident, alzheimers).
- e. Oral—nonverbal apraxia beyond 2 months.
- f. Accompanying peripheral vision or hearing defects.

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IV. OXYGEN THERAPY: REVIEW FOR MEDICAL NECESSITY

- A. **STANDARDS OF PRACTICE:** The review process shall employ the Guidelines for Respiratory Care Services and Skilled Nursing Facilities developed jointly by the American Association of Respiratory Care and the American Health Care Association.
- B. Technical abbreviations used in Item VII - Oxygen Therapy.
ABG - Arterial Blood Gases
AVF - Augmented Voltage Foot
O₂ - Oxygen Level
paO₂ - Partial Pressure of Oxygen
paCO₂ - Partial Pressure of Carbon Dioxide
Oxygen Sats - Oxygen Saturation Levels
HCT - Hematocrit Level
mm Hg - Millimeters of Mercury
- C. General Indicators.
1. PaO₂ < 55 mm Hg or saturation < 88% while breathing ambient air.
 2. Optimum medical management.
 - a. Ancillary respiratory medications.
 - b. Physiotherapy.
 - c. Associated adverse conditions addressed.
 3. PaO₂ of 56-59 mm Hg or saturation of 91% in the presence of one or more of the following:
 - a. Cor pulmonale (p wave greater than 3 mm in standard leads II, III, or AVF).
 - b. Right ventricular hypertrophy.
 - c. Erythrocytosis (Hct > 56%).
 - d. Reduced tissue oxygenation accompanied by neuropsych signs (i.e., tachycardia, tachypnea, dyspnea, cyanosis, diaphoresis chest pain or tightness, change in sensorium).
 4. For that resident whose clinical condition prohibits evaluation of arterial oxygen saturation without supplemental oxygen:
 - a. Oxygen saturation while on O₂ < 92%.
 - b. PaO₂ < 60 mm Hg.

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D. Continuous Oxygen

1. When hypoxemia criteria are established and met (found under general indicators) then continuous oxygen is appropriate.
2. Monitor clinical parameters (signs and symptoms associated with continuous oxygen needs).
3. Monitor results of oxygen therapy which measure functional improvement (i.e., ABF or oxygen Sats or improved symptoms).

E. Noncontinuous Oxygen

1. Documentation of clinically relevant hypoxemia related to exercise or nocturnal or sleeping even though "daytime resting" PaO₂ or saturation may be adequate.
2. "As needed" (PRN) is generally not a valid reason to have available unless clinical documentation establishes hypoxemia and there exist circumstances why a person would not fit the category for continuous, exercise related, or sleep related.

F. Monitoring Condition

1. Acute use based on baseline PaO₂/O₂ saturation and PaCO₂ in establishing initial oxygen dose.
2. The need for repeat use of ABG or oximetry depends upon the frequency the dose of oxygen is changed and/or the resident's altered clinical condition in response to therapy.
3. Use of ABG versus oximetry.
 - a. Dependent on equipment available at facility or in area.
 - b. Dependent upon the professionals available to secure arterial oxygen parameters and monitor or manage any subsequent condition.
 - c. Dependent upon the arterial parameters needed.
 - d. Oximetry is useful for non-hypercapneic persons as a guide to oxygen dose initiation. It is simpler for nursing to utilize or log data. It is essentially nontraumatic for the resident (with few clinical complications). The data or results must be interpreted carefully per equipment variations applied (i.e., peripheral vascular disease). It may not correlate with PaO₂ drawn in the same resident.

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4. There are no criteria or resident requirements which fit all clinical situations to mandate ABG or oximetry testing for a stable resident. At least quarterly testing is advisable for the stable oxygen dependent condition. This is considered a reasonable interval to assess progress and establish continued need. More frequent may be warranted by physician judgment or changing clinical status. For the person with hypoxemia and hypercapnia establish regimen of oxygen or other treatment is suggested to be reassessed by ABG or oximetry every 1—2 months; again with exacerbation of illness or changing parameters of function closer monitoring intervals may be warranted.

G. Conservation of oxygen.

1. Devices in use that may be considered by treatment team or facility includes:
 - a. Transtracheal oxygen delivery system.
 - b. Reservoir mustache nasal prong.
 - c. Reservoir pendant nasal system.
2. Adjusting up to 50% of the volume of oxygen delivered or used can be achieved with a decrease in overall expense but consideration has to be made for safety or complication in the transtracheal use. Also of note is the endurance or longevity factor associated with the pendant type product. It may not be as cost effective as the nasal prong as it is not as enduring.

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V. RESPIRATORY THERAPY: REVIEW FOR BILLING AS ANCILLARY

- A. **Standards of Practice:** The review process shall employ the Guidelines for Respiratory Care Services and Skilled Nursing Facilities developed jointly by the American Association of Respiratory Care and the American Health Care Association.
- B. Technical abbreviations used in Item VIII — Respiratory Therapy.
FEVI — Forced Expired Volume after one second
FVC — Forced Vital Capacity
IPPB — Intermittent Positive Pressure Breathing
MDI — Metered Dose Inhalers
PFT — Pulmonary Function Tests
- C. Indications.
1. Provide direct management of the following:
 - a. Aerosolized drug delivery.
 - b. Humidification.
 - c. Secretion care management.
 - d. Tracheostomy care.
 - e. Oxygenation changes (when possible in Conjunction with obtaining ABGs. or oximetry checks).
 2. Teaching resident self treatment of the following:
 - a. Aerosol.
 - b. Breathing exercises.
 - c. Cough guidelines.
 3. Ongoing treatment requires the following:
 - a. Specialty staff to assess response if new therapy.
 - b. Specialty staff if respiratory therapy service is beyond usual nursing staff expertise (do the nurses provide the resident respiratory therapy on weekends when respiratory therapist is not available).
 - c. If chronic clinical condition or nursing care plan therapy, documentation is necessary by the respiratory therapist and physician to support ongoing necessity of therapist versus nursing staff or resident administered therapy.

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4. For a self administered system of therapy the following is required:
 - a. Resident must demonstrate proper use of the equipment or medication delivery system.
 - b. Resident delivery system monitored by nursing staff.
 - c. Respiratory therapist intervention would be expected to drop when metered dose inhalers and nebulizers are utilized as resident or nursing staff can provide this therapy at the nursing care plan level.
5. The following situation may necessitate a respiratory therapist:
 - a. Initial MDI or nebulization treatments may be performed by ancillary staff if no nursing staff is familiar with the mode of therapy. Should this occur, the ancillary respiratory therapist is responsible for providing instructions to nursing staff so that nursing staff can then provide MDI or nebulization treatments safely.

D. Aerosol Therapy.

1. Physician must order the medication utilized for the delivery system.
2. Mode of delivery or humidity needed may be determined by the respiratory therapist in the initial setting.
3. The simpler modalities are as effective and can be given in the absence of a respiratory therapist provided the facility staff are trained or comfortable or available to do this. Verify by physician order the acceptability of this process.
4. Metered dose inhalers (MDI) with or without spacers properly utilized were effective compared to nebulizers or IPPB (IPPB has been shown to be no more effective generally than MDI or nebulizers).
5. MDI should be attempted in bronchodilator therapy as simpler for nursing and residents to manage.
6. Nebulizer (compressed air driven apparatus) should be utilized when MDI is shown to be inadequate for the treatment of an individual clinical condition. It may also have to be utilized if a specific drug is not available via the MDI system.

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7. Nebulizer therapy can be performed by the resident who is capable of reliable self care when trained by respiratory therapist or nursing staff. It can also be performed with safety by facility staff. The need for a respiratory therapist should be evident in charting. It is reasonable to utilize the respiratory therapist initially to verify resident response to nebulizer therapy but once considered stable or nursing care plan then the facility staff or resident should assume nebulizer therapy responsibility.
8. IPPB (intermittent positive pressure breathing) has principally been replaced by MDI or nebulizer therapy as the acceptable delivery system. It is no more effective than other equipment. If utilized documentation should exist why other simpler and potentially less complication associated mode care not utilized. This therapy would potentially require a respiratory therapist beyond the initial phase of administration.
9. The use of inhalers and bronchodilator therapies should always be supported by persistent symptoms, physical findings as well as PFT (Pulmonary Function Test). This information should be found in the respiratory therapist's notes. Usually documented is impairment of airway or lungs function and should be considered greater than "mild" dysfunction. Criteria for PFT which indicate moderate obstruction follow:
 - a. FEV1 51—59% predicted.
 - b. FEV1/FVC 41—59% predicted.
 - c. Clinical evidence that there is a reversible component to support use of an aerosol bronchodilator.
10. The frequency of treatment (MDI or nebulizers) should be reasonable for the illness or clinical presentation. Generally, aerosolized bronchodilator are given at intervals that correspond to duration of effect of the drug or aerosol treatment. (Monitor significantly reduced PRN schedules as there could be question to the need for the drug in this form of delivery frequency).

E. Monitoring Therapy.

1. It is the physician's responsibility to assess the plan of treatment and document the resolution if short term therapy. In the event of a chronic diagnosis the physician must document the reasonable nature of ongoing therapy.

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2. In the event of long term treatment the following information should be available:
 - a. Annual Pulmonary Function Test (PFT) should be available.
 - b. Peak flow rates—to serve as intermittent indicators to be determined by the attending physician or respiratory therapist.
3. Appropriateness of therapy should be questioned in the following situations:
 - a. Chest physiotherapy or use of mucolytic aerosols when no secretions are evident after treatment course is “completed.”
 - b. Aerosol therapy for interstitial lung disease as primary diagnosis for treatment initiation.
 - c. Aerosol therapy when irreversible airflow obstruction exists.