

**Technical Criteria for Reviewing  
Ancillary Services for Pediatrics**

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**Cabinet for Health Services  
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## Technical Criteria for Reviewing Ancillary Services for Pediatrics

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### I. PHYSICAL THERAPY: REVIEW FOR BILLING AS AN ANCILLARY SERVICE- PEDIATRICS

- A. **Standards of Practice:** The review process shall employ the standards of practice by the American Physical Therapy Association.
- B. Deficiency of function must be of significant level that an ancillary clinician's expertise in designing or conducting program in presence of potential gain is documentable.
1. Therapeutic exercise/gross motor development program.
    - a. Exercises are designed to utilize neuro developmental techniques, reflex integration, and perceptual-sensory motor integration to assist to reach the maximum potential possible. The Therapist's expertise is required to design, supervise or conduct a program in which there is a need for developmental or functional gain.
    - b. Progress is demonstrated at predictable intervals.

#### Indication for Denial

- a. Medically unstable.
  - b. Goal seems unreasonable.
  - c. Participation level questioned.
  - d. Plateaued or achieved goals..
  - e. Lacks documentation.
2. Chest Therapy-when respiratory therapy is not available.

Postural drainage, including positioning to loosen secretions and promote drainage is within the training of the Physical Therapist. This is addressed with the bed fast, non-ambulatory or resident with pneumonia.

#### Indication for Denial

- a. In-house Respiratory therapist.
- b. Managed by nursing/caregiver.
- c. Condition clinically stable and manageable by nursing/caregiver.

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3. Equipment and/or orthopedic appliances assessed, fitted, adjusted and monitored. The pediatric resident utilizes equipment throughout his/her lifetime.
  - a. Modify or monitor wheelchairs.
  - b. Upon M.D. prescription, order, modify, monitor orthotic appliances. Work to train care givers and residents use of appliances. This includes, but is not limited to, braces, walkers, crutches, canes, oyster shells and back braces.

### Indication for Denial

- a. Unteachable.
  - b. Repetitive use for distance or endurance.
  - c. Resident can perform trained excersises.
  - d. Nursing can monitor fit.
  - e. Nursing can monitor maintenance of equipment of minor deficiencies/repairs.
4. Assessment to provide individualized, detailed documentation of the function of a particular child. This is generally performed at 6-12 month intervals or when change is indicated. Assessment may include, but is not limited to:
    - a. Postural reflex integration.
    - b. Status of sensory, motor, neuro motor and musculoskeletal systems.
    - c. Perceptual motor development.
    - d. Joint range of motion.
    - e. Analysis of functional independence.
    - f. Postural deviations.
    - g. Gait analysis.
    - h. Developmental level, including gross and fine motors.
    - l. Adaptive equipment needs.
    - j. Resident's and/or family needs.

### Indication for Denial

- a. Resident medically unstable.
- b. Lacks developmental maturation changes to justify reassessment.
- c. Lacks potential for gain.

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5. Consultation and caregiver instructions are required as changes occur with the pediatric resident. Consultation to staff, such as nursing, respiratory therapy, classroom personnel, is needed to assist in the overall care. This consultation is needed in order to utilize the skills of the therapist for instruction and ongoing programming. This could include, but not limited to instruction for:
  - a. Application of orthopedic appliances.
  - b. Use of adaptive equipment
  - c. Positioning.
  - d. Routine exercises.
  - e. Routine gait training.

### Indication for Denial

- a. Resident not able to participate medically.
- b. Lacks changes (regression or improvement) to justify consultation.
- c. Lacks potential for gain.
- d. Nursing/caregiver can provide modification.

### 6. 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 at nursing care plan level-routine program with no complex features.
- c. Inappropriate use in vascular compromised setting (or labile or poor blood pressure control).
- d. Cold sensitivity disorder.

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7. Low-Energy Laser.
  - a. Wound tissue healing.
  - b. Pain management over trigger points.

### Indication for Denial

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

8. Transcutaneous Electric Nerve Stimulation (TENS).

- a. Post-operative incisional pain.
- b. Orthopedic analgesia acute or chronic, apply to either trigger point or peripheral nerve.
- c. Low back pain chronic.
- 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 capable of managing (or resident can set-up, apply or control) after initial evaluation of response or control setting achieve.

9. Heat Therapy.

- a. Treatment actively of musculoskeletal mobility or pain problems as part of a therapist-driven treatment plan.
- b. In conjunction with exercise regimen.

### Indication for Denial

- a. Active disorder controlled, mostly comfort.
- b. Complexity manageable by nursing.
- c. Resident not responsive or non-communicable.
- d. Ischemic limbs or other site or atrophic skin.

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### 10. 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 spasms.
- 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 sores.

### 11. Hydrotherapy.

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

#### Indication for Denial

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

### 12. Iontophoresis

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

#### Indication for Denial

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

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### 13. Prosthesis.

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

#### Indication for Denial

- a. Unteachable
- b. Lacks above features.
- c. Poor wound healing.
- d. Other inappropriate conditions (such as bilateral above knee amputation over age of 45, or below elbow amputee and flail shoulder or elbow).
- e. Repetitive exercises, and/or use of pre-prosthesis stump shinker prior to prosthetic fitting can be carried as part of the nursing care plan.
- f. Repetitive use for distance or endurance only and level change has been achieved.
- g. Assisting routine care of equipment.
- h. Resident can perform trained exercises with supervision by nursing.

### 14. Electromyographic Biofeedback.

- a. Spasticity or weakness as part of 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 treatment plan time frame.
- b. Conditions of questionable effectiveness.
- c. Resident lacks voluntary control or motivation.

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### 15. High Pressure Wound Irrigation.

- a. Heavily contaminated wounds.

#### Indication for Denial

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

### 16. 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 AN ANCILLARY SERVICE-PEDIATRICS

- 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 significant level that an ancillary clinician's expertise in designing or conducting the program in the presence of potential gain is documentable. Uniform terminology of Occupational Therapy developed by the American Occupational Therapy Association shall be used to define deficiency of function.

1. Therapeutic activities shall address appropriate Occupational Therapy performance areas of:

Activities of daily living.  
Work activities.  
Play or leisure activities.

Treatment in each performance area shall address specific performance components. These performance components consist of

Sensory Motor Skills.  
Cognitive Skills.  
Psychological Skills.

(Please refer to attached copy of uniform terminology for Occupational Therapy definitions of performance areas and performance components.)

- a. Implementation of therapeutic activities requires a therapists' 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 interval for remediation of dysfunction where appropriate.
- c. Compensatory and prevention intervention models are also utilized in treatment of individuals with chronic conditions and developmental disabilities. This may include adaptive equipment, technology, graded assistance, and task modification. Documentation of outcomes shall reflect progress in function in performance areas and performance components.

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### Indication of Denial

- a. Lacks documented details of dysfunction or goal.
- b. Stability of resident questioned.
- c. Participation level a hindrance.
- d. Unreasonable goal.
- e. Plateaued, goal achieved, or needs only repetitive ROM, ADL coaching, or stimulation environment as by nursing care plan.
- f. Adaptive equipment lacks usable functionality.
- g. Nursing/caregiver can provide preventative/compensatory techniques for ongoing application.

### 2. Activities of Daily Living

- a. Grooming.
- b. Oral Hygiene.
- c. Toilet Hygiene.
- d. Dressing.
- e. Feeding and eating.
- f. Medication routine.
- g. Socialization.
- h. Functional mobility

Highest level of function shall be consistent with developmental levels. Prerequisite skills in identified performance areas shall be targeted and progress documented, including use of compensatory strategies and adaptive equipment. When a plateau is reached, periodic re-evaluation are allowed and the ancillary clinician may resume treatment program if resident shows documented changes in function in performance area and performance components. Updating and progressing the activities of daily living program requires the expertise of the ancillary clinician and periodic program update with care-giver instruction are allowable.

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- a. Condition prevents engaging techniques or use of device.
  - b. Technique learned, resident or nursing staff can carry-out routinely.
  - c. Chronic condition limits functional gain-documentation shows failure of prescribed technique over reasonable time span.
  - d. Unable to advance or use more complex dexterity level due to cognitive limits-documentation shows failure of compensatory strategies over reasonable time span.
3. Splinting and fabrication/prescription for adaptive equipment/environments.
- a. Fabrication and fitting of splints and adaptive devices restore function in neuromuscular and/or motor performance components to support highest practicable level of function as part of intervention plan.
  - b. Therapist shall document prescribed use of splints or devices and instruct caregiver
  - c. Therapist shall monitor, fit and repair splint or device and periodically make necessary modifications for fit, safety and changes in function.
  - d. Design of adaptive equipment and environment to improve function in performance areas and specified performance components that requires expertise of an ancillary clinician. Include safety devices and restraint alternatives in keeping with OBRA guidelines for restraint free environments.

### Indication for Denial

- a. Documentation does not support need.
  - b. Use of splint/device/environment incorporated into routine and nursing care plan (re-evaluation and modification by Occupational Therapist are allowable when changes in function occur.)
4. Consultation and Care-Givers Instruction  
Consultation with care-givers shall be provided to establish consistency with nursing care plan and to prepare for discharge.
- a. Clinically relevant deficiencies are present.
  - b. Potential gain is evident
  - c. The resident demonstrates developmental maturation changes that need ancillary OT input.

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### III. SPEECH THERAPY: REVIEW FOR BILLING AS AN ANCILLARY SERVICE-PEDIATRICS

- A. Preferred practice patterns for professions of Speech-language Pathology and Audiology shall be those developed by the American Speech and Hearing Association.
- B. Deficiency of function must be of significant level that an ancillary clinician's expertise in designing or conducting program in presence of potential gain, or, as a preventative measure, is documentable.
  - 1. Speech (articulation, fluency, voice), Language and Cognitive Disorders.
    - a. Utilization of standardized testing measures.
    - b. Treatment is conducted to achieve improved, altered, augmented, or compensated speech, language and cognitive communication behaviors or processes.
    - c. Treatment may include prerequisite skill training which includes, but not limited to cooing, respiratory support for vocalization, oral stimulation, vocal turn taking, inflection, object permanence, cause and effect knowledge, problem-solving, gesture/sign.
    - d. Prosthetic/adaptive device training (e.g. speaking valve, adaptive switch, adapted toys, etc.)
    - e. Equipment maintenance at interval consistent with:
      - 1. Physical and/or developmental change.
      - 2. New equipment problem beyond nursing/caregiver expertise.

#### Indication for Denial

- a. Standardized and nonstandardized measures reveal age appropriate speech-language and cognitive skills.
- b. No documentable change in status during the last six (6) months, as indicated by therapy notes, recertification, care plan and the annual speech-language evaluation.

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2. Oral pharyngeal function (dysphagia) and related disorders.
  - a. Applicable diagnostic testing with confirmed abnormality.
  - b. The absence of, or restricted oral presentation of food and/or liquids.
  - c. Strategies that alter behavior (e.g., posture, rate, learned airway protection measures, method of intake, prosthetic use, etc.)
  - d. Modification of swallowing activity in coordination with respiratory or alternation of bolus characteristics (e.g. volume, consistency).
  - e. Equipment maintenance at interval consistent with:
    1. Physical and/or developmental change.
    2. New equipment problem beyond nursing/caregiver expertise.

### Indication for Denial

- a. Standardized tests, observations, instrumental diagnostic procedures, structural assessment and functional assessment reveal normal parameters of the swallow system and other oral pharyngeal functions.
  - b. No documentable change in status during the last six (6) months, as indicated by therapy notes, recertification, care plan and the annual speech-language evaluation.
  - c. Lack new equipment problem.
  - d. Nursing/caregiver can perform maintenance/repair.
  - e. Lack of nursing/caregiver training.
3. Augmentative and Alternative Communication (AAC) Systems.
    - a. Training of prerequisite skills for AAC includes, but not limited to visual attention, visual tracking, choice making activities, cause and effect knowledge and anticipation of outcome.
    - b. Determination of the MC intervention program (assessment).
    - c. Selection and the development of an effective AAC system..
    - d. Service implementation and system integration into the natural environment. Includes care-giver training.
    - e. Follow-up and ongoing evaluation.
    - f. Equipment maintenance at interval consistent with:
      1. Physical and/or developmental change.
      2. New equipment problem beyond nursing/caregiver expertise.

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### Indication for Denial

- a. Standardized and nonstandardized measures reveal age appropriate speech-language skills, utilizing AAC.
  - b. No documentable change in status during the last six (6) months, as indicated by therapy notes, recertification, care plan and annual speech-language evaluation.
  - c. Lack new equipment problem.
  - d. Nursing/caregiver can perform maintenance repair.
  - e. Lack of nursing/caregiver training.
4. Aural Habilitation/Rehabilitation.
- a. Comprehension and production of language in oral, augmentative, signed or written modalities.
  - b. Speech and voice production.
  - c. Auditory training.
  - d. Speech reading.

### Indication for Denial

- a. Audiological assessment reveals adequate hearing acuity.
  - b. Standardized and nonstandardized measures reveal age appropriated speech-language and cognitive skills. U,
  - c. No documentable change in status during the last six (6) months, as indicated by therapy notes, recertification, care plan and annual speech language evaluation.
  - d. Lack new equipment problem.
  - e. Nursing/caregiver can perform maintenancelrepair.
  - f. Lack of nursinglcaregiver training.
5. Consultation and care Giver Instruction
- a. Consultation and caregiver instructions are required as changes occur with the pediatric resident. Consultation to staff, such as nursing, respiratory therapy, classroom personnel, is needed to assist in the overall care. This consultation is needed in order to utilize the skills of the therapist for instruction and ongoing programming, taking into consideration:

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1. Clinically relevant deficiencies.
2. Potential gain.
3. Demonstrable developmental maturation changes that require ancillary ST input.

### Indication for Denial

- a. Resident not able to participate medically.

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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. The pediatric criteria not found here shall be based on age appropriate parameters obtained from current textbook baselines.

Technical abbreviations used in item IV-Oxygen Therapy:

1. ABG-Arterial Blood Gases;
2. AVF-Augmented Voltage Foot;
3. O<sub>2</sub>- Oxygen Level;
4. PaO<sub>2</sub> -Partial Pressure for Oxygen;
5. PaCO<sub>2</sub> -Partial Pressure of Carbon Dioxide;
6. Oxygen Sats-Oxygen saturation levels;
7. HCT-Hematocrit Level; and
8. mm Hg- Millimeters of Mercury

#### C. General Indicators

1. Oxygen saturation < 93% or PaO<sub>2</sub> <65 mm Hg while breathing room air.
2. Optimum medical management.
  - a. Ancillary respiratory medications.
  - b. Physiotherapy.
  - c. Associated adverse conditions addressed.
3. PaO<sub>2</sub> of 56-59 mm Hg or saturation of 91 percent in the presence of one or more of the following:
  - a. Cor pulmonale (p wave greater than 3mm in standard leads II, III, or AVF).
  - b. Right ventricular hypertrophy.
  - c. Erythrocytosis (Hct >56 percent).
  - d. Reduced tissue oxygenation accompanied by neuropsych signs (i.e., tachycardia, tachypnea, dysnea, cyanosis, diaphoresis chest pain or tightness, change in sensorium.)

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4. For that resident whose clinical condition prohibits evaluation of arterial oxygen saturation without supplemental oxygen:
  - a. Oxygen saturation <95% or PaO<sub>2</sub> <65 mm Hg while breathing oxygen. Monitor functional improvement resulting from oxygen therapy (e.g., oxygen saturation, PaO<sub>2</sub>, symptomatic improvement).

### 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., ABG 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" PaO<sub>2</sub> or saturation may be adequate.
2. "As needed" (PRN) is generally not a valid reason to have oxygen available unless clinical documentation establishes hypoxemia and there exist circumstances why the person would not fit the category for continuous oxygen or, exercise related or sleep related non-continuous oxygen. An exception is made for brittle pediatric residents who have a significantly decreased PaO<sub>2</sub> with feeding, communication, or crying.

### F. Monitoring Condition

1. Acute use based on baseline PaO<sub>2</sub> or O<sub>2</sub> saturation and PaCO<sub>2</sub> in establishing initial oxygen dose.
2. The need for repeat use of ABG or oximetry depends upon the frequency the dose of oxygen is changes or changes in the resident's clinical condition in response to therapy.

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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 conditions.
  - c. Dependent upon the arterial parameter needed.
  - d. Oximetry is useful for non-hypercapnic persons as a guide to oxygen dose initiation. It is simpler for nursing to utilize or log data. It is essentially non-traumatic 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 PaCO<sub>2</sub> drawn in the same resident.
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 established continued need. More frequent testing may be warranted by physician judgment or changing clinical status. For the person with hypoxemia and hypercapnia, the established regimen of oxygen or other treatment is suggested to be reassessed by ABG or oximetry every 1 to 2 months. With exacerbation or illness of changing parameters of function, closer monitoring intervals may be warranted.

### G. Conservation of oxygen.

1. Devices in use that may be considered by the 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 percent 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 AN ANCILLARY PEDIATRICS

- 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. The pediatric criteria not found here shall be based on age appropriate parameters obtained from current textbook baselines.
- B. Technical abbreviations used in Item VIII-Respiratory Therapy.  
FEV1-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 ABG's or oximetry checks).
  2. Teaching resident self treatment of following:  
(In pediatric care patient education is dependent on age and severity of the physical and mental disabilities of the child):
    - a. Aerosol.
    - b. Breathing exercises.
    - c. Cough guidelines.

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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 therapist 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.
  
4. For 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 therepaist 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 instruction to nursing staff so that nursing staff can then provide MDI or nebulization treatments safely.
  - b. If the pediatric patient has an acute or ongoing unstable pulmonary problem, including deterioration in status, complex respiratory care needs, frequent monitoring, weaning of modalities, complications of primary disease or therapies.

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### c. 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 respiratory therapist provided the facility staff are trained and 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.
- (5) MDI (if child is on dosage compatible) 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.
- (7) Nebulizer therapy can be performed safely by facility staff. Nebulizer therapy can also be performed by the resident who is capable of reliable self care when trained by respiratory therapist or nursing staff. 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 required a respiratory therapist beyond the initial phase of administration.
- (9) The use of inhalers and bronchodilator therapy should always be supported by persistent symptoms and physical findings as well as PFT (Pulmonary Function Test) if applicable. 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 based on PFTs is not usually feasible in the pediatric population due to the inability to follow commands for inspiration, expiration or sustained

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apnea. PFT criteria is most applicable to adults and older, cooperative children. PFT criteria for continued therapy is not required for children who are unable to perform PFT accurately and who require continued therapy because of the continued respiratory problems.

- (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). Children, however, may have respiratory problems which are very episodic and presence of sporadically used respiratory treatments may often be appropriate treatment for short-lived, episodic, respiratory problems.

### d. 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.
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.
  - c. If accurate pulmonary function testing or peak flow rates are not possible because the pediatric patient is unable to perform them, documentation of the need for long term therapy can be made on the basis of the frequency of acute episodes during the previous year as described in the care record.

### D. Respiratory staffing of neonatal and young children.

1. Older children or adolescents with pulmonary disorders amenable to active respiratory treatment will require the intervention and monitoring of a respiratory therapist in most situations. This is principally for the purpose of addressing changing oxygenation needs and secretions clearing problems

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generally found in these residents.

2. If a plateau has been indicated via documentation then one could consider transferring care to the facility staff for the uncomplicated, stable lung disorder. This could encompass the following care needs:
  - a. Aerosol therapy.
  - b. Routine trach care.
  - c. Nursing care plan oxygen administration.
3. Nursing care plan service or plateau should be supported by documentation in the ongoing nursing assessment and the respiratory therapist's notes. The potential for changing to facility staff provided or supervised therapy administration or delivery systems exists if resident is stable or nursing care plan with chronic condition. This care provision change should be considered less complex, less costly and should not adversely affect the efficacy of the treatment.