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Prescribing Therapy Services for Children With Motor Disabilities:

A Collaborative Approach Is Key

by Marcie Ward, M.D.

When pediatric patients have motor disabilities, pediatricians and other primary-care physicians can provide valuable expertise and promote enhanced patient outcomes by recommending appropriate therapy and adaptive equipment early on.

Primary-care physicians best understand a child's medical conditions and comorbidities — whether transient, static or progressive — in the context of the family. Such information can help determine future therapy and equipment needs. It also provides everyone on the therapy team — therapists, families and other physicians — with a better understanding of a child's condition and with clearly defined goals for maximizing the child's abilities.

Insurance Reimbursement and Therapy

When physicians take part in planning a child's therapy and equipment, the child is more likely to receive care that is coordinated across medical, school, child-care, recreational and community settings. Coordinated care is more likely to meet insurance-company guidelines, because many insurance companies require a physician's authorization before reimbursing for therapies. Insurers also typically reimburse based on episodes of care. Before approving additional services, insurers corroborate the likelihood of patients' functional improvements.

For example, a physician might recommend goal-directed therapy to improve a patient's capabilities. The patient's therapy team identifies specific goals and coordinates therapies and equipment to meet the goal.

As they do with therapies, insurance companies limit how much and how often they'll pay for adaptive equipment. To prevent reimbursement glitches for families, it's helpful if physicians and others involved in therapy and equipment planning are familiar with reimbursement guidelines before making recommendations. Teamwork among families, therapists, and primary- and specialty-care physicians can make it easier to select from treatment options and advocate for the unique needs of each child.

The Physician's Role in Planning Therapy

An American Academy of Pediatrics (AAP) survey asked pediatricians on whom they would rely — themselves, specialists, therapists or equipment vendors — to make decisions regarding therapies and durable medical equipment (DME). DME includes orthotics, walkers, gait trainers, standers and wheelchairs.

For some categories, physicians reported that they would take an active role in prescription decisions. Their reliance on specialty consultations increased appropriately as the conditions in question became increasingly complex. Still, some physicians in all categories said they rely on nonphysician health providers to recommend therapy and DME. A little more than half said they participated "most of the time" in recommending professional services or therapies as part of early-intervention programs. One-third said they participated less than half of the time, and 14 percent said they never participated (see survey highlights, page 2).

The study postulated that physicians might not participate in such cases because they aren't familiar with recommending such services and devices for children who have complex needs. To address this issue, the AAP recommended that primary-care physicians seek the advice of therapists and pediatric rehabilitation medicine specialists while working as a team to make recommendations.

Directing and Coordinating Therapy and Equipment:

Survey Shows Many Physicians Rely on Nonphysician Providers

In November 2004, the American Academy of Pediatrics (AAP) mailed surveys to 500 pediatricians listed in its directory. By asking about practices in prescribing therapy and durable medical equipment (DME) for children who have special health-care needs, the survey attempted to quantify objectively how pediatricians direct and coordinate such services. The 217 survey respondents indicated that they provide some services to children with special health-care needs.

Summary of Results

- Except for providing a diagnosis, the majority of pediatricians don't regularly comply with AAP recommendations for prescribing therapies and DME in medical and educational settings.
- Physicians who were trained before 1980 tend to follow AAP recommendations more closely than later graduates do.
- The majority of physicians were willing to defer decisions about treatment and goals to nonphysician health-care providers and, in some cases, to equipment providers.
- More than two-thirds of respondents indicated that they would sign a prescription for therapy if a therapist initiated it.
- Most respondents noted that they would sign a wheelchair prescription a therapist sent to them.
- Few of the physicians surveyed said they felt comfortable in determining the appropriateness of leg orthoses and arm/hand-brace prescriptions.
- Most respondents said they would see a patient before signing a therapy or DME prescription if they hadn't seen that patient in the past year.
- More than three-quarters of respondents would prefer to let a therapist or an educator set therapy goals.
- Only 58 percent of pediatricians reported receiving a detailed progress report once or twice a year. Approximately one-fifth received no reports on patients in school-based programs.

After physicians and other therapy team members determine a patient's therapy needs, they can develop a therapy plan. The AAP offered the following guidelines for prescription writing.

Diagnosis

Physicians should include the diagnosis on a therapy prescription. When the cause of a disability isn't apparent, physicians must provide an accurate description of a child's medical condition and note whether the child has a transient, static or progressive impairment. Include possible associated problems, such as learning disabilities, mental retardation, sensory impairment, speech disorders, emotional difficulties and seizure disorders.

Anticipated goals

Physicians should establish therapy goals with the family, patient and therapists at the beginning of a therapy program. Realistic functional goals should be specific and measurable.

Precautions

List any medical conditions that might be harmed by certain movements or other therapeutic activities. For example, children with myopathies must exercise below their fatigue thresholds so their symptoms don't worsen.

Type of therapy

Physicians might prescribe one or more types of therapy. Physical therapy focuses on gross-motor skills and functional mobility, including positioning, sitting, making transitional movements, walking with or without assistive devices, propelling a wheelchair, and transferring. Occupational therapy focuses on fine-motor, visual-motor, and sensory-processing skills needed for basic activities, such as eating, dressing, grooming, toileting, bathing and handwriting. Speech and language pathology addresses speech, language, cognitive, communication and swallowing skills.

Frequency

Physicians should indicate how many therapy sessions each week are recommended. The frequency of therapy typically changes as a result of discussions and collaboration among physicians, families and therapists.

Duration

Whether a patient is progressing toward goals can determine how long therapy continues. Depending on the results of an initial therapy plan — typically four to eight weeks is a good starting point — physicians can work with the family and therapist to evaluate the efficacy of therapy. Then the team can decide whether to

continue with the current care plan, modify the care plan or discontinue therapy.

Long-term therapy might not present an advantage over short-term therapy. A therapy team can identify home-exercise programs and teach such programs to families. Therapists also recommend recreational and community activities that support continuing gains in functional skills. Home programs and community activities can augment patients' existing therapy sessions while reducing the frequency and duration of those sessions.

Equipment needs

Physicians should consider DME for patients whose conditions or functions are likely to improve with the use of such tools. Therapists often recommend assistive technology and DME to enhance gains in functional skills. If physicians aren't sure which orthotic or assistive-mobility devices a patient needs, consulting with a child's therapist or referring the patient to a pediatric rehabilitation medicine physician is helpful. Children who have complex needs also might need such a referral.

Setting Goals and Monitoring Progress

Therapy goals should focus on improving a child's abilities and participation in activities, not solely on the diagnosis or age of the child. It's important that goals for episodes of care address any apparent gaps between a child's capabilities and current abilities. Therapists' input can be invaluable at this stage. By now, they've had a number of weeks to evaluate a child's abilities and identify specific goals.

Setting therapy goals provides everyone involved with clearly defined expectations. The team should communicate regularly and re-evaluate programs periodically. During reassessments, the therapy team can review whether:

- A patient is achieving identified goals
- A patient needs new therapy objectives and/or home- and community-based programs
- The therapy and/or equipment continues to be warranted

It's helpful if physicians regularly ask families to describe how therapy has helped their children improve function or increase participation in community activities. A family's inability to identify how rehabilitation is helping a child could indicate that the therapy plan needs adjusting. Adjustments could involve equipment changes in addition to frequency, duration and type of therapy.

Setting functional goals for children who have motor disabilities can be difficult, especially for physicians who aren't familiar with assessing such children. Seeking the advice of therapists and pediatric rehabilitation medicine specialists is often beneficial if physicians find it difficult to identify realistic goals for such complicated patients.

Author's Profile

Marcie Ward, M.D.

Marcie Ward, M.D., a pediatric rehabilitation medicine physician, provides services to patients at Gillette's Burnsville and St. Paul locations. She treats pediatric patients who have cerebral palsy, spina bifida, muscular dystrophy, brain injuries, spinal-cord injuries and other conditions.

Ward received her medical degree from the University of Illinois College of Medicine in Chicago. She completed an internship in family medicine — with a pediatric concentration — at Broadlawns Medical Center in Des Moines, Iowa, and a physical medicine and rehabilitation residency at Carolinas Medical Center in Charlotte, N.C. She also finished a fellowship in pediatric rehabilitation at The Children's Hospital in Denver, Colo.

Ward is board-certified in physical medicine and rehabilitation. She is a member of the American Academy of Physical Medicine and Rehabilitation; the American Academy for Cerebral Palsy and Developmental Medicine; and the Association of Academic Physiatrists.

To schedule an appointment with Ward, call Gillette at 651-229-3944 or 800-719-4040.

Gillette Therapy Services

Gillette provides therapy services at:

- Burnsville Clinic
- New Brighton Clinic
- Minnetonka Clinic
- St. Paul campus

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- Raise awareness of the primary and secondary effects of neuromuscular diseases on cardiopulmonary function
- Increase the skill of primary-care physicians and specialists who manage the cardiopulmonary needs of patients with neuromuscular diseases

For more information, visit our Web site at www.gillettechildrens.org. Or contact Jason Kelecic at 651-312-3176, 800-719-4040 (toll-free), or jkelecic@gillettechildrens.com.

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With hands-on workshops: A course for primary-care physicians

Friday, Dec. 2, 2005 — 7:30 a.m. to 5 p.m.
Gillette Children's Specialty Healthcare,
St. Paul, Minn.

This course will examine a variety of musculoskeletal conditions that often are first evaluated by a primary-care physician, nurse practitioner or physician assistant. The course will consist of small-group and hands-on sessions. The sessions will highlight and review points of the physical examination, diagnostic work-up, and treatment-planning process for various pediatric musculoskeletal conditions.

For more information, visit our Web site at www.gillettechildrens.org. Or contact Patrick Cavanaugh at 651-229-1758, 800-719-4040 (toll-free), or pcavanaugh@gillettechildrens.com.

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