Pediatric rehabilitation medicine

Background

Pediatric rehabilitation medicine (PRM) is a subspecialty of physical medicine and rehabilitation (PM&R) that utilizes an interdisciplinary approach to evaluating infants, children, and adolescents with temporary or permanent disabilities. PRM physicians (pediatric physiatrists) also develop treatments to maximize their patients’ functional capabilities and minimize the psychological, social, and vocational effects of disability. The need for rehabilitation can be due to trauma, disease, surgery, or congenital disability. Rehabilitation management of children with physical impairments is a challenging service that requires the integration and identification of functional capabilities, the selection of rehabilitation intervention strategies, and an understanding of growth, development, and the continuum of care.

PRM physicians treat children with conditions such as:
* Musculoskeletal injuries
* Sports injuries
* Amputations
* Burns
* Neurologic conditions
* Stroke
* Psychological disorders

The pediatric physiatrist heads the rehabilitation team, which may include psychologists, physical and occupational therapists, speech pathologists, nurses, social workers, teachers, and other appropriate specialists. Because the family is the one constant in the child’s life and the source of the child’s greatest support, the rehabilitation leader often uses a family-centered approach. Family members are considered a part of the team and are encouraged to attend team meetings and participate in treatment sessions. Depending on the needs of the individual patient, the rehabilitation team can be expanded.

The American Board of Medical Specialties (ABMS) authorizes the American Board of Physical Medicine and Rehabilitation (ABPMR) to offer subspecialty certification in PRM to candidates who are ABPMR diplomates in good standing. Although PRM is not an ABMS-approved subspecialty of pediatrics, physicians interested in dual-specialty certification in pediatrics and PM&R can qualify for admission to the certification exams of both the American Board of Pediatrics (ABP) and the ABPMR. A special agreement exists between the ABP and the ABPMR whereby an applicant may fulfill the training requirements for certification in pediatrics and PM&R by completing five years of
combined training. Candidates may qualify to sit for the PRM subspecialty examination by completing a two-year Accreditation Council for Graduate Medical Education (ACGME)-accredited PRM fellowship following PM&R residency training or a one-year ACGME-accredited fellowship in PRM after PM&R/pediatrics combined residency training.

The American Osteopathic Board of Physical Medicine & Rehabilitation and the American Osteopathic Board of Pediatrics do not offer subspecialty certification exams in PRM.

**Involved specialties**

Pediatric physiatrists

**Positions of specialty boards**

**ABPMR**

To become certified in the subspecialty of PRM, candidates must submit an application for approval and successfully complete the ABPMR subspecialty examination in PRM. Applicants for subspecialty certification in PRM must:

- Be current ABPMR diplomates in good standing
- Have a current, valid, and unrestricted license to practice medicine in at least one jurisdiction in the United States, its territories, or Canada
- Complete two years of an ACGME-accredited PRM fellowship after a PM&R residency or a one-year ACGME-accredited fellowship in PRM after PM&R/pediatrics combined or consecutive residency training
- Be evaluated semiannually by the program director
- Be recommended for admissibility to the PRM subspecialty examination by the fellowship program director upon successful completion of the training program in PRM

Candidates satisfactorily completing these training requirements may sit for the PRM subspecialty examination, a computer-based examination consisting of 280 multiple-choice questions. Upon approval of the application and successful completion of the examination, the ABPMR will grant a 10-year, time-limited subspecialty certificate in PRM. To maintain certification, certificants must participate in the ABPMR Maintenance of Certification program.

**Positions of societies, academies, colleges, and associations**

**AAPM&R**

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) does not publish information regarding the education or competency of or delineation of privileges for pediatric physiatrists. However, the organization
states that pediatric physiatrists are involved in treating children with cerebral palsy, spina bifida, brachial plexus palsy, and torticollis. Additionally, these physicians manage children with traumatic brain injury, congenital and acquired amputations, and both acute and long-term spinal cord injury as well as children with muscle diseases.

The AAPM&R states that pediatric physiatrists use medication and physical therapy to care for children with these neuromuscular conditions. According to the AAPM&R, “Depending on the case, PM&R physicians may prescribe physical therapy to relax the muscles and improve strength. With neurological disorders—cerebral palsy, birth brachial plexus palsy and spina bifida—PM&R doctors use electrodiagnostic medicine to determine the degree of spasticity and damage, then treat the condition. Pediatric physiatrists also provide prescriptions for durable medical equipment such as wheelchairs, bracing, and communication devices.”

The AAPM&R is also dedicated to upholding the ABMS/ACGME six core competencies for quality patient care set forth by the ABMS Maintenance of Certification program for PRM.

**ACGME**

In its *Program Requirements for Graduate Medical Education in Pediatric Rehabilitation Medicine*, the ACGME states that fellowship programs in PRM must provide the fellow opportunities to develop a specific set of attitudes, knowledge, and psychomotor skills in pediatric rehabilitation conditions to ensure the fellow’s ability to enhance the quality of care available to individuals and their families.

PRM fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. With regard to patient care, fellows:

➤ Must have a sufficient variety, depth, and volume of clinical experiences. The educational program should take into consideration the fellow’s documented past educational and patient care experiences. The program must provide for the fellow to spend a significant amount of time with responsibility for the direct care of hospitalized as well as nonhospitalized patients. Fellows must devote at least one-third of their clinical experience to the care of hospitalized patients and at least one-third to nonhospitalized patients.

➤ Must attain knowledge and competency in the following areas of PRM:

- Normal growth and development, including physical growth, attainment of developmental skills (language and communication skills, physical skills, cognitive skills, emotional skills and maturity, academic achievement/learning skills), transitional issues, metabolic status, biomechanics, the effects of musculoskeletal development on function, sexuality, avocational interest development, wellness and health promotion, and aging issues for adults with congenital or childhood-onset disabilities.
Pediatric rehabilitation medicine

- Application, efficacy, and selection of PRM assessment tools, including enabling/disabling process, general health measures, developmental attainment measures, general functional measures, and specific outcomes measures
- Identification and management of common PRM conditions and complications, including nutrition, bowel management, bladder management, gastroesophageal reflux, skin protection, pulmonary hygiene and protection, sensory impairments, sleep disorders, spasticity, DVT prophylaxis, congenital and acquired lymphedema, feeding disorders, swallowing dysfunction, seizure management, and behavioral problems
- Principles and techniques for general pediatric rehabilitative therapeutic management, including early intervention, age-appropriate functional training, programs of therapy, play (avocation), therapeutic exercise, electrical stimulation and other modalities, communication strategies, oral motor interventions, discharge planning, educational and vocational planning, transitional planning, adjustment to disability support, and prevention strategies
- Evaluation and prescription for assistive device technology, including orthotics, prosthetics, wheelchairs and positioning, aids, interfaces and environmental controls, augmentative/alternative communication, environmental accessibility, electrical stimulation, and dynamic splinting
- Principles and techniques of PRM procedures, including spasticity management and electrodiagnosis
- Interpretation of diagnostic studies commonly ordered in PRM
- Rehabilitation management of:
  - Musculoskeletal disorders and trauma, including sports injuries
  - Cerebral palsy
  - Spinal dysraphism and other congenital anomalies
  - Pediatric spinal cord injury
  - Pediatric traumatic brain injury
  - Limb deficiency/amputation
  - Neuromuscular disorders
  - Rheumatologic and connective tissue disorders, including but not limited to specific conditions such as juvenile rheumatoid arthritis, spondyloarthropathies, dermatomyositis, and Lyme disease
  - Burns
  - Peripheral nerve injuries
- Administration, including principles of organizational behaviors and leadership; quality assurance; cost efficiency; knowledge of healthcare systems, community resources, and support services regulations pertaining to service provision (external reviews, inpatient services, outpatient services, home care, school-based programs and capabilities); skills for effective advocacy; medical legal aspects (child protective services, guardianship, liability); professionalism; and ethics
- Psychological, social, and behavioral aspects of rehabilitation management, including family-centered care
- Requesting appropriate medical-surgical consultations from other specialties
Should follow individual patients longitudinally. Should have progressive responsibility with lesser degrees of supervision as they advance and demonstrate additional competencies. The program should be flexible but sufficiently structured to allow for such graded responsibility.

PRM fellows must also demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care. With regard to medical knowledge, fellows:

- Should have basic science didactic curriculum taught by faculty and a self-directed learning program to address the theoretical and clinical principles that form the fundamentals of managing patients with pediatric medicine disorders. Pathophysiology, discussion and knowledge of clinical manifestations, and management problems should constitute the major topics of study.
- Should have specialty content taught by faculty in anesthesiology, emergency medicine, family medicine, genetics, neurology, neurosurgery, orthopedic surgery, pediatrics (including the relevant subspecialties), pediatric surgery, plastic surgery, psychiatry, radiology, surgery, and urology who take an active role in providing instruction in the areas of their practices relevant to PRM.
- Must have experiences that include case-oriented multidisciplinary conferences, journal clubs, and quality management seminars relevant to clinical care in PRM.
- Must have conferences with sufficient quality and frequency to provide in-depth coverage of the major topics in PRM.

Positions of accreditation bodies

**CMS**

CMS has no formal position concerning the delineation of privileges for PRM. However, CMS’ *Conditions of Participation (CoP)* define a requirement for a criteria-based privileging process in §482.22(c)(6), stating, “The bylaws must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.”

§482.12(a)(6) states, “The governing body must assure that the medical staff bylaws describe the privileging process. The process articulated in the bylaws, rules or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:

- Individual character
- Individual competence
- Individual training
- Individual experience
- Individual judgment
The governing body must ensure that the hospital’s bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners.”

Specific privileges must reflect activities that the majority of practitioners in that category can perform competently and that the hospital can support. Privileges are not granted for tasks, procedures, or activities that are not conducted within the hospital, regardless of the practitioner’s ability to perform them.

Each practitioner must be individually evaluated for requested privileges. It cannot be assumed that every practitioner can perform every task, activity, or privilege specific to a specialty, nor can it be assumed that the practitioner should be automatically granted the full range of privileges. The individual practitioner’s ability to perform each task, activity, or privilege must be individually assessed.

CMS also requires that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

CMS’ CoPs include the need for a periodic appraisal of practitioners appointed to the medical staff/granted medical staff privileges (§482.22[a][1]). In the absence of a state law that establishes a time frame for the periodic appraisal, CMS recommends that an appraisal be conducted at least every 24 months. The purpose of the periodic appraisal is to determine whether clinical privileges or membership should be continued, discontinued, revised, or otherwise changed.

**The Joint Commission**

The Joint Commission has no formal position concerning the delineation of privileges for PRM. However, in its *Comprehensive Accreditation Manual for Hospitals*, The Joint Commission states, “The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege” (MS.06.01.03).

In the introduction for MS.06.01.03, The Joint Commission states that there must be a reliable and consistent system in place to process applications and verify credentials. The organized medical staff must then review and evaluate the data collected. The resultant privilege recommendations to the governing body are based on the assessment of the data.

The Joint Commission introduces MS.06.01.05 by stating, “The organized medical staff is responsible for planning and implementing a privileging process.” It goes on to state that this process typically includes:

- Developing and approving a procedures list
- Processing the application
- Evaluating applicant-specific information
➤ Submitting recommendations to the governing body for applicant-specific delineated privileges
➤ Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision
➤ Monitoring the use of privileges and quality-of-care issues

MS.06.01.05 further states, “The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.”

The EPs for standard MS.06.01.05 include several requirements as follows:
➤ The need for all licensed independent practitioners who provide care, treatment, and services to have a current license, certification, or registration, as required by law and regulation
➤ Established criteria as recommended by the organized medical staff and approved by the governing body with specific evaluation of current licensure and/or certification, specific relevant training, evidence of physical ability, professional practice review data from the applicant’s current organization, peer and/or faculty recommendation, and a review of the practitioner’s performance within the hospital (for renewal of privileges)
➤ Consistent application of criteria
➤ A clearly defined (documented) procedure for processing clinical privilege requests that is approved by the organized medical staff
➤ Documentation and confirmation of the applicant’s statement that no health problems exist that would affect his or her ability to perform privileges requested
➤ A query of the NPDB for initial privileges, renewal of privileges, and when a new privilege is requested
➤ Written peer recommendations that address the practitioner’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism
➤ A list of specific challenges or concerns that the organized medical staff must evaluate prior to recommending privileges (MS.06.01.05, EP 9)
➤ A process to determine whether there is sufficient clinical performance information to make a decision related to privileges
➤ A decision (action) on the completed application for privileges that occurs within the time period specified in the organization’s medical staff bylaws
➤ Information regarding any changes to practitioners’ clinical privileges, updated as they occur

The Joint Commission further states, “The organized medical staff reviews and analyzes information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege” (MS.06.01.07).

In the EPs for standard MS.06.01.07, The Joint Commission states that the information review and analysis process is clearly defined and that the decision
process must be timely. The organization, based on recommendations by the
organized medical staff and approval by the governing body, develops criteria
that will be considered in the decision to grant, limit, or deny a request for privi-
leges. The criteria must be consistently applied and directly relate to the quality
of care, treatment, and services. Ultimately, the governing body or delegated
governing body has the final authority for granting, renewing, or denying clini-
cal privileges. Privileges may not be granted for a period beyond two years.

Criteria that determine a practitioner’s ability to provide patient care, treatment,
and services within the scope of the privilege(s) requested are consistently
evaluated.

The Joint Commission further states, “Ongoing professional practice evalua-
tion information is factored into the decision to maintain existing privilege(s), to
revise existing privileges, or to revoke an existing privilege prior to or at the time
of renewal” (MS.08.01.03).

In the EPs for MS.08.01.03, The Joint Commission says there is a clearly defined
process facilitating the evaluation of each practitioner’s professional practice, in
which the type of information collected is determined by individual departments
and approved by the organized medical staff. Information resulting from the
ongoing professional practice evaluation is used to determine whether to con-
tinue, limit, or revoke any existing privilege.

**HFAP**

The Healthcare Facilities Accreditation Program (HFAP) has no formal position
concerning the delineation of privileges for PRM. The bylaws must include the
criteria for determining the privileges to be granted to the individual practitio-
ners and the procedure for applying the criteria to individuals requesting privi-
leges (03.01.09). Privileges are granted based on the medical staff’s review of an
individual practitioner’s qualifications and its recommendation regarding that
individual practitioner to the governing body.

It is also required that the organization have a process to ensure that practitio-
ners granted privileges are working within the scope of those privileges.

Privileges must be granted within the capabilities of the facility. For example, if
an organization is not capable of performing open-heart surgery, no physician
should be granted that privilege.

In the explanation for standard 03.01.13 related to membership selection crite-
ria, HFAP states, “Basic criteria listed in the bylaws, or the credentials manual,
include the items listed in this standard. (Emphasis is placed on training and
competence in the requested privileges.)”
The bylaws also define the mechanisms by which the clinical departments, if applicable, or the medical staff as a whole establish criteria for specific privilege delineation.

Periodic appraisals of the suitability for membership and clinical privileges is required to determine whether the individual practitioner’s clinical privileges should be approved, continued, discontinued, revised, or otherwise changed (03.00.04). The appraisals are to be conducted at least every 24 months.

The medical staff is accountable to the governing body for the quality of medical care provided, and quality assessment and performance improvement (03.02.01) information must be used in the process of evaluating and acting on re-privileging and reappointment requests from members and other credentialed staff.

**DNV**

DNV has no formal position concerning the delineation of privileges for PRM. MS.12 Standard Requirement (SR) #1 states, “The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges.”

The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society.

Regarding the medical staff standards related to clinical privileges (MS.12), DNV requires specific provisions within the medical staff bylaws for:

- The consideration of automatic suspension of clinical privileges in the following circumstances: revocation/restriction of licensure; revocation, suspension, or probation of a DEA license; failure to maintain professional liability insurance as specified; and noncompliance with written medical record delinquency/deficiency requirements
- Immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner’s Medicare/Medicaid status
- Fair hearing and appeal

The Interpretive Guidelines also state that core privileges for general surgery and surgical subspecialties are acceptable as long as the core is properly defined.

DNV also requires a mechanism (outlined in the bylaws) to ensure that all individuals provide services only within the scope of privileges granted (MS.12, SR.4).

Clinical privileges (and appointments or reappointments) are for a period as defined by state law or, if permitted by state law, not to exceed three years (MS.12, SR.2).
Individual practitioner performance data must be measured, utilized, and evaluated as a part of the decision-making for appointment and reappointment. Although not specifically stated, this would apply to the individual practitioner’s respective delineation of privilege requests.

**CRC draft criteria**

The following draft criteria are intended to serve solely as a starting point for the development of an institution’s policy regarding PRM. The core privileges and accompanying procedure list are not meant to be all-encompassing. They define the types of activities, procedures, and privileges that the majority of practitioners in this specialty perform. Additionally, it cannot be expected or required that practitioners perform every procedure listed. Instruct practitioners that they may strikethrough or delete any procedures they do not wish to request.

**Minimum threshold criteria for granting core privileges in pediatric rehabilitation medicine**

**Basic education:** MD or DO  
**Minimal formal training:** Applicants must have completed an ACGME program in PM&R or an accredited combined or consecutive residency training in both PM&R and pediatrics. Applicants must then complete an ACGME-approved PRM fellowship training program or complete at least three years of practice experience primarily in PRM.  
**Required current experience:** Applicants must be able to demonstrate that they have provided PRM inpatient or consultative services for at least 50 patients in the past 12 months.

**References**

If the applicant is recently trained, a letter of reference should come from the director of the applicant’s training program. Alternatively, a letter of reference may come from the applicable department chair and/or clinical service chief at the facility where the applicant most recently practiced.

**Core privileges in PRM**

Core privileges for PRM include the ability to admit, evaluate, diagnose, and provide consultation and medical therapy to children with congenital and childhood-onset physical impairments, including related or secondary medical, physical, functional, psychosocial, and vocational limitations or conditions, with an understanding of the life course of disability. Physicians may also provide care to patients in the intensive care setting in conformance with unit policies. They may also assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.
The core privileges in this specialty include the following procedures and such other procedures that are extensions of the same techniques and skills:

➤ Performance of history and physical exam
➤ Management of common medical issues in pediatric rehabilitation
➤ Physical examination of pain/weakness/numbness syndromes (both neuromuscular and musculoskeletal) with a diagnostic plan and/or prescription for treatment that may include the use of physical agents and/or other interventions
➤ Evaluation, prescription, and supervision of medical and comprehensive rehabilitation goals and treatment plans
➤ Rehabilitation management of:
  – Musculoskeletal disorders and trauma, including sports injuries
  – Cerebral palsy
  – Spinal dysraphism and other congenital anomalies
  – Pediatric spinal cord injury
  – Pediatric traumatic brain injury
  – Limb deficiency/amputation
  – Neuromuscular disorders
  – Rheumatologic and connective tissue disorders, including but not limited to specific conditions such as juvenile rheumatoid arthritis, spondyloarthropathies, dermatomyositis, and Lyme disease
  – Burns
  – Peripheral nerve injuries
➤ Performance and interpretation of:
  – Electrodiagnosis, including electromyography and nerve conduction studies
  – Ergometric studies
  – Gait laboratory studies
  – Muscle/muscle motor point biopsies
  – Small, intermediate, or major joint arthrograms
  – Radiological and lab procedures, including fluoroscopy

Special noncore privileges in PRM

If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the specific threshold criteria governing the exercise of the privilege requested, including training, required previous experience, and maintenance of clinical competence. Noncore privileges include the administration of sedation and analgesia.

Reappointment

Reappointment should be based on unbiased, objective results of care according to a hospital’s quality assurance mechanism.
Applicants in PRM must be able to demonstrate current competence and an adequate volume of experience (100 patients) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

In addition, continuing education related to PRM should be required.

For more information

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