Dr. Brown's Medical Q and A 5.24.22

Casey Lewis- Achieving the Goal: An Integrated Multidisciplinary NICU

Q: Should we be using the diagnosis PFD (Pediatric Feeding Disorder) in the NICU??

A: I certainly describe the risk of potentially acquiring PFD within the NICU medical teams and at times, within my medical documentation. Regarding the logistics of this, I recommend consulting Feeding Matters to get more concrete feedback, as this organization has been championing the advocacy of PFD.

Q: Do you bill for each session in the NICU? Are you able to bill for services as a speech therapist if doing oral care, positive touch, or four-handed care?

A: I do bill for each session- after all, what I offer is a skilled intervention that took years to be able to provide! If I spend at least 8 minutes with an infant, the session is billed for and a note is written within the medical record. Yes, I also bill for oral care, positive touch, four handed care; my goals for the infant reflect that these interventions are necessary for facilitating neuroprotective care.

Q: I'm a SLP of 3 years, I've mostly worked in peds settings. I really want to work in NICU but haven't been given an opportunity because I don't have NICU experience. What suggestions would you give for gaining experience or other ways to gain necessary skill sets?

A: When I am involved in interviews for additional NICU therapists, I always see if the individual has experience in critical care units. I also like to see the individual's CE transcript and specifically want to see what CEUs were taken in the area of dysphagia. I also like to see if any mentorships have been completed, and what leadership roles the individual has been a part of. My advice is to try to get your foot in the door in an acute care setting, first. Of course, this is my own professional opinion!

Q: How did you get full team buy-in for the Ultra Preemie nipple? Despite education and presentation of data, we continue to face resistance from some RNs and some neos, especially with infants whose volumes have plateaued. They continue to think the infant has to work harder with the Ultra Preemie.

A: My advice is to consult with Dr. Brown's Medical regarding this topic specifically, as they are the manufacturer of the product, and have a skilled team of Speech-Language Pathologists to help you! I also suggest forging a strong relationship with at least one Neonatologist as well as one Neonatal Nurse Practitioner. When a fragile infant is learning to consume intake by mouth- safety is the goal, always. I can't speak to the complexities of your own medical team, but I also suggest getting involved (or form) a developmental committee and work to establish nurse champions to help guide the feeding initiatives, with your expertise!

Q: What is the time frame your unit uses for the protected breastfeeding window before a bottle is ever introduced, and how have you been successful in helping promote that precious window and not forcing bottles too quickly?

A: In my unit, there isn't a concrete time frame. It ebbs and flows based on the family's wishes as well as the infant's current abilities. Breastfeeding is often important to hospital initiatives, and perhaps you could start a Quality Improvement project to improve breastfeeding duration. Additionally, parent satisfaction is held paramount among NICUs, and this is one way to increase satisfaction. Consider offering a presentation to your NICU leadership and Neonatology Leadership team.

Q: Is there a CPT code that correlates with that new ICD code? How do you generally bill for your services in the NICU?

A: *Please consult with Feeding Matters regarding this question. Services are billed for feeding intervention or developmental intervention- how you bill is something to consult directly with your specific hospital leadership.*

Q: If you don't have any standing orders, what would you see as first steps?

A: Provide a presentation to your Medical Director and provide literature from NANT!