Pediatric Outpatient Intensive Feeding Programs

Policy Number: OUTPATIENT 050.1 T1
Effective Date: May 1, 2021

Instructions for Use

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Related Policy

- Formula and Specialized Food

Coverage Rationale

A Feeding Disorder refers to a condition in which an individual is unable or refuses to eat, or has difficulty eating, resulting in failure to grow normally. Feeding disorders should not be confused with eating disorders, such as anorexia, which are more common in adolescence and adulthood. Some common types of feeding disorders in children include, but are not limited to, adipsia (the absence of thirst or the desire to drink); dysphagia (difficulty in swallowing); food avoidance; inability to self-feed; choking, gagging, or vomiting when eating; and difficulty transitioning from enteral feedings.

Outpatient therapy is the most medically appropriate setting for these services unless the individual independently meets coverage criteria for a different level of care. Inpatient admission may be appropriate for management of acute problems in children who are undergoing operative procedures, are seriously ill with certain medical conditions, or at risk of harm. Note: See the following Oxford policy for more information regardig issues related to topics addressed in the Administrative Policy titled Formula and Specialized Food.

Services related to treating a pediatric feeding disorder are considered medically necessary when all of the following criteria are met:

- A thorough medical evaluation has revealed a significant feeding disorder associated with a medical condition (e.g., failure to thrive, prematurity, neurologic conditions, developmental disability, gastrointestinal disorders, gastrostomy tube). The evaluation should include:
  - A thorough medical evaluation including neurologic, metabolic and gastrointestinal (specifically malabsorption and gastroesophageal reflux disease) clinical nutritional work-up as indicated; and
  - An evaluation to identify any structural or functional abnormalities; and
  - An evaluation of possible behavioral components

  and
- Adequate treatment for any contributing underlying medical conditions, if present, has occurred without resolution of the feeding problem; and
- Conventional outpatient treatment has not succeeded. A two-month trial of conventional treatment that minimally utilizes a single modality must be documented; and
- A treatment plan, individualized to each child, is developed and includes diagnosis, problem list, proposed treatment plan with specific interventions, and estimated length of treatment and
- Physician will coordinate and oversee the treatment program; and
- The treatment plan includes active participation/involvement of a parent or guardian.

Note: Regular documentation supporting significant progress toward treatment goals is required to determine the medical necessity of continuation of a pediatric intensive multidisciplinary feeding program.

Pediatric intensive feeding programs are interdisciplinary programs that have been proposed to provide treatment for patients with impairment of oral intake. These programs combine medical and behavioral health techniques and provide these services on an intensive basis. The multidisciplinary services may include but are not limited to:

- Gastroenterology
- Behavior psychology
- Nutrition
- Social work
- Occupational therapy
- Speech therapy

Note: When individuals receive concurrent physical, occupational, behavioral, or speech therapy, the therapists should provide different treatments that reflect each therapy discipline's unique perspective on the individual's impairments and functional deficits and not duplicate the same treatment. They must also have separate evaluations, treatment plans, and goals.

A pediatric intensive multidisciplinary feeding program is considered not medically necessary for any of the following:

- Treatment provided is to prevent or slow deterioration in function or prevent reoccurrences
- Treatment intended is to improve or maintain general physical condition
- When a home feeding program can be utilized to continue therapy
- Therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline
- Swallowing/feeding therapy for food aversions that are meeting normal growth and developmental milestones

Interventions for behavioral therapy may be covered under the member's behavioral health benefits. Please check benefit plan descriptions.

Limitations and Exclusions

Some plans limit coverage of medically necessary speech therapy and occupational therapy. Speech therapy of the developmentally delayed child has included training to improve the functioning of oral and pharyngeal muscles. This oral-motor training is usually introduced before the emergence of speech. Members should check their benefit plan descriptions for any applicable benefit plan limitations and exclusions on coverage for speech therapy services.

Prior Authorization Requirements

Prior authorization is required in all sites of service.

Notes:

- Participating providers in the office setting: Prior authorization is required for services performed in the office of a participating provider.
- Non-participating/out-of-network providers in the office setting: Prior authorization is not required but is encouraged for out-of-network services. If prior authorization is not obtained, Oxford will review for out-of-network benefits and medical necessity after the service is rendered.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies may apply.

CPT Code	Description
92526	Treatment of swallowing dysfunction and/or oral function for feeding

Clinical Evidence

Swallowing and feeding disorders in children and infants are complex and may have multiple causes. Underlying medical conditions that may cause dysphagia may include, but are not limited to: (Palmer, 2000; Rudolph and Link, 2002)

- Neurological disorders (e.g., cerebral palsy)
- Disorders affecting suck-swallow-breathing coordination (e.g., bronchopulmonary dysplasia}
- Structural lesions (e.g., neoplasm)
- Connective tissue disease (e.g., muscular dystrophy)
- Iatrogenic causes (e.g., surgical resection, medications)
- Anatomic or congenital abnormalities (e.g., cleft lip and/or palate)

Rarely can one reason or cause for feeding disorders be isolated or identified. The most prominent medical diagnoses that can lead to feeding disorders include:

- Apraxia
- Autism/Pervasive developmental disorders
- Brain injury
- Cardiac problems
- Cerebral palsy
- Children with tube feeding
- Cleft palate
- Constipation
- Failure to thrive
- Feeding difficulties
- Food allergies
- Malabsorption
- Muscular dystrophy
- Neurological problems
- Oral dysphagia
- Prematurity
- Reflux
- Respiratory complications (e.g., pneumonia)
- Short gut/bowel syndrome

There is no consensus regarding the definition of FTT, or how long a growth concern should exist before a child meets criteria for FTT. However, the term may be attributed to a child who, with observation of growth over time, has any of the following:

- Weight below the 3rd or 5th percentile for gestation-corrected age and sex on more than one occasion. Special growth charts for selected genetic syndromes should be used when indicated (e.g., for children with Down syndrome, Turner syndrome, etc); or
- Weight less than 80 % of ideal weight for age, using the standard growth charts of the NCHS; or
- Depressed weight for length (i.e., weight age less than length age, weight for length less than10th percentile); or
- A rate of weight gain that causes a decrease in 2 or more major percentile lines (90th, 75th, 50th, 25th, 10th, and 5th) over time (e.g., from 75th to 25th); or
- A rate of daily weight gains less than that expected for age.

According to the recommendations of the American Academy of Pediatrics (AAP, 2010), screening for nutrition risks and problems is an expected part of routine preventive health services. In a review of the literature on feeding problems of infants and toddlers, Bernard-Bonnin (2006) concluded that:

- Feeding problems in early childhood often have multi-factorial causes and a substantial behavioral component, and
- Family physicians have a key role in detecting problems, offering advice, managing mildly to moderately severe cases, and
- More complicated cases should be referred to multidisciplinary teams.

When the feeding problem is severe or complex, medical causes of FTT have been treated, and initial treatment efforts by a single discipline (e.g., occupational therapist, speech language pathologist) have failed, intensive treatment is considered. A referral is made to an interdisciplinary team for assessment and intervention in order to evaluate and treat all factors influencing growth. A nutrition assessment completed by a registered dietitian obtains information needed to rule out or confirm a nutrition related problem. Nutrition assessment consists of an in-depth and detailed collection and evaluation of data in the following areas: anthropometrics, clinical/medical history, diet, developmental feeding skills, behavior related to feeding, and biochemical laboratory data. During the assessment, risk factors identified during nutrition screening are further evaluated and a nutrition diagnosis is made. The assessment may also reveal areas of concern such as oral-motor development or behavioral issues that require referral for evaluation by the appropriate therapist or specialist. Other members of the interdisciplinary team may include behaviorists, occupational therapist, physical therapist, speech language pathologist/therapist, social worker, and home health care providers.

Some clinical settings may offer comprehensive outpatient clinics with interdisciplinary care models called “pediatric intensive feeding programs” or “feeding clinics” that are designed to evaluate, diagnose, and treat children with severe or complex feeding and swallowing difficulties. These interdisciplinary clinics are intended to provide greater environmental control, greater frequency of treatment, accelerated learning by increased contact with caregivers, and frequent medical and nutrition monitoring to provide clinicians with additional treatment options (e.g., appetite manipulation, swallow induction). An interdisciplinary team of specialists work with the child and family to address the multiple factors involved with eating. Programs vary across locations but generally focus on the feeding problems of infants and children up to 16 years of age. Typically lasting 4- 8 weeks, key aspects of the program include direct observation behavior assessment, approaches for increasing and decreasing feeding behavior, skill acquisition, transfer of treatment gains, and parent training.

Most feeding disorders have underlying organic causes; however, evidence indicates that abnormal feeding patterns are not solely due to organic impairment and that disordered feeding in a child is seldom limited to the child alone but is also a family problem, therefore, engagement of caregivers and family are important in ensuring success of a feeding program.

Interventions are comprehensive and include behavioral modification to alter the child's inappropriate learned feeding patterns and parent education and training in appropriate parenting and feeding skills. A majority of feeding problems can be resolved or greatly improved through medical, oral motor, and behavioral therapy. Behavioral feeding strategies have been applied successfully even in organically mediated feeding disorders. In many intensive treatment programs, the intervention involves 3 phases:

1. The child is fed directly by the therapist to establish a new set of feeding responses,
2. Parents are introduced into the feeding environment, and
3. Parents feed their child with clinicians coaching remotely.

References

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Medical Technology Assessment Committee. [*URG-17.01*]

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Policy History/Revision Information

Date	Summary of Changes
05/01/2021	• New Clinical Policy

Instructions for Use

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare Oxford reserves the right to modify its Policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice.

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