Anthem

Clinical UM Guideline

Subject: Intensive Programs for Pediatric Feeding Disorders
Guideline #: CG-MED-37
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Description

This document addresses the use of intensive programs for pediatric feeding disorders. The term "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 refusal; inability to self-feed; taking too long to eat; choking, gagging, or vomiting when eating; inappropriate mealtime behavior; and picky eating according to food type and texture.

Note: Please see the following documents for more information regarding issues related to topics addressed in this guideline:

- CG-BEH-15 Activity Therapy for Autism Spectrum Disorders and Rett Syndrome
- CG-MED-08 Home Enteral Nutrition

Clinical Indications

Medically Necessary:

An *evaluation** to confirm a suspected diagnosis of pediatric feeding disorder** is considered **medically necessary** for children whose difficulties began **under five (5) years of age** who meet *either* of the following criteria:

A. Failure to meet developmental milestones of growth and development, including *either* of the following:
   1. Significant weight loss or reduction or cessation of weight gain over the previous 2 months; **or**
   2. Crossing 2 or more major weight percentiles downward;
   or
B. Growth and development milestones have been met, but only via nutritional support consisting of high-calorie foods, nutritionally deficient foods, or both, and transition to nutritionally and calorically appropriate foods is warranted.

An *evaluation** to confirm a suspected diagnosis of pediatric feeding disorder** is considered **medically necessary** for **children of any age** who meet *either* of the following criteria:

A. Severe, complex neurologic or neuromuscular disorders are present and are felt to be contributing to failure in meeting developmental milestones of growth and development, including *either* of the following:
   1. Reduction or cessation of weight gain over the previous 2 months; **or**
   2. Crossing 2 or more major weight percentiles downward;
   or
B. Significant change in feeding behavior is felt to be compromising the child's nutritional status, including *any* of the following:
   1. Reduction or cessation of weight gain over the previous 2 months; **or**
   2. Crossing 2 or more major weight percentiles downward.

*This 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.

**Possible situations that could initiate an evaluation for a pediatric feeding disorder include:

- Child coughs, chokes or gags while eating or immediately after eating; **or**
- Child demonstrates a history of chronic pulmonary difficulties which may include diagnosis of aspiration pneumonia; **or**
- Vocal cord dysfunction; **or**
- Food is being suctioned out of the child's airway; **or**
- Weight gain is poor and difficult and this is thought to be secondary to an oral-sensorimotor, pharyngeal, or swallowing dysfunction; **or**
- Difficulty initiating a swallow; **or**
- Structural abnormalities are present that may interfere with the development of a normal swallow; **or**
- Chronic food refusal; **or**
- "Pocketing" of food during meals; **or**
- Excessive length of time getting child to eat (meals lasting greater than 30 minutes); **or**
- Neuromotor involvement affecting oral-sensorimotor coordination and respiration; **or**
- Chronic poor growth or compromised nutritional status; **or**
- Difficulties transitioning from tube or gastrostomy tube feedings to oral feedings.

A *reevaluation*† is considered **medically necessary** when there are *any* of the following:

A. New clinical findings; **or**
B. A rapid change in individual's status; **or**
C. Failure to respond to therapy interventions (for example, speech and language, occupational therapy, physical, and behavioral therapy).

†There are several routine reassessments that are not considered reevaluations. These include ongoing reassessments that are part

of each skilled treatment session, progress reports, and discharge summaries. Reevaluation is a more comprehensive assessment that usually includes the components of the initial evaluation, and may also include components such as:

- Data collection with **objective** measurements taken based on appropriate and relevant assessment tests and tools using comparable and consistent methods; **or**
- Making a judgment as to whether skilled care is still warranted;**or**
- Organizing the composite of current problem areas and deciding a priority/focus of treatment;**or**
- Identifying the appropriate intervention(s) for new or ongoing goal achievement; **or**
- Modification of intervention(s); **or**
- Revision in plan of care if needed;**or**
- Correlation to meaningful change in function;**or**
- Deciphering effectiveness of intervention(s).

The *treatment* of a pediatric feeding disorder is considered **medically necessary** when **all** of the following criteria are met:

A. A thorough medical evaluation has confirmed the presence of a feeding disorder;**and**
B. Adequate treatment for any contributing underlying medical conditions, if present, has occurred without resolution of the feeding problem; **and**
C. 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.

Note: Other issues that may be addressed include specific dietary interventions or special formulas, positioning during feeding, behavioral interventions and family or caregiver education. Intensity of treatment may vary from short-term intermittent outpatient visits to more intensive treatment programs. Inpatient or intensive outpatient treatment programs may be warranted for severe cases, such as malnutrition or failure to thrive, unstable electrolyte disorders, potentially serious allergic reactions to food, significant difficulty transitioning from tube feedings to oral feedings, etc.

Not Medically Necessary:

Evaluation and treatment for pediatric feeding disorders are considered **not medically necessary** when the criteria above have not been met.

A feeding disorder treatment program is considered **not medically necessary** for children who can eat and swallow with normal functioning, but who are “picky eaters” or have selective eating behaviors and yet continue to meet normal growth and developmental milestones, and other medically necessary criteria above have not been met.

Inpatient admission for a pediatric intensive feeding program is considered **not medically necessary,** except when the individual requires facility-based care related to acute medical complications of the feeding disorder (for example, malnutrition or failure to thrive, unstable electrolyte disorders, potentially serious allergic reactions to food, significant difficulty transitioning from tube feedings to oral feedings, etc.).

Duplicate therapy†† is considered **not medically necessary.**

††Duplicate treatment refers to when individuals receive concurrent physical, occupational, behavioral, or speech therapy, and there is overlap of services provided. 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 across treatment plans. They must also have separate evaluations, treatment plans, and goals.

Maintenance feeding disorder treatment programs are considered **not medically necessary.**

Note: A maintenance program consists of treatments or activities that preserve the individual's present level range, strength, coordination, balance, pain, activity, function, etc. and prevent regression of the same parameters. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur. In certain circumstances, the specialized knowledge and judgment of a qualified therapist may be required to establish a maintenance program, however, the repetitive therapy services to maintain a level would be considered not medically necessary.

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

When services may be Medically Necessary when criteria are met:

CPT	
99199	Unlisted special service, procedure or report [when specified as services related to intensive programs for pediatric feeding disorders]
ICD-10 Diagnosis	
	All diagnoses

When services are Not Medically Necessary:
For the services related to intensive programs for pediatric feeding disorders when criteria are not met or when the code describes a procedure or situation designated in the Clinical Indications section as not medically necessary.

Discussion/General Information

Pediatric feeding disorders include a wide range of problems that interfere with normal eating activities and result in inadequate caloric or nutritional intake, resulting in compromise of the child’s growth and development. This is confirmed when the child fails to consume a sufficient volume or variety of food to maintain weight or to sustain a normal growth rate (Crosby, 2007; Piazza, 2008). Goday (2019) notes:

> Feeding is a complex process that requires interaction of the central and peripheral nervous systems, oropharyngeal mechanism, cardiopulmonary system, and gastrointestinal (GI) tract with support from craniofacial structures and the musculoskeletal system. This coordinated interaction requires acquisition and mastery of skills appropriate for a

child's physiology and developmental stage.

Signs and symptoms of a significant feeding disorder may include refusal to eat or drink; difficulty swallowing, inability to self-feed at an appropriate age, requiring an abnormally long time to eat, choking, gagging, or vomiting when eating, or other inappropriate mealtime behaviors. If such feeding problems occur for a prolonged period of time, they will have a significant effect upon the child's nutritional intake, affecting growth rates and may result in frequent illnesses, or death in severe cases. Such disorders may also be accompanied by behavioral problems such as hitting, biting, kicking, tantrums, and vomiting at mealtime as an attention-getting strategy.

Feeding disorders are fairly common in infants and toddlers, with approximately 25-35% of these children experiencing some difficulties with feeding (Kodak, 2008). The incidence of severe feeding problems has been reported to be as high as 40-70% in infants born prematurely or in children with chronic medical conditions (Rogers, 2004). Malnutrition is found in approximately 25-50% of children diagnosed with pediatric feeding disorder, particularly those children with chronic disease or neurodevelopmental disorder (Goday, 2019).

Feeding disorders may result from a wide range of causes, including medical conditions (for example, food allergies, neurologic or neuromuscular disease, gastroesophageal reflux, and others), structural or functional abnormalities (for example, defects of the palate), or behavioral issues (for example, crying or tantrums that prevent successful completion of mealtimes). In most cases, there is likely a complex interaction among multiple causative factors. For example, medical problems such as gastroesophageal reflux disease (GERD) may cause eating to be painful. Early experiences with pain during eating can cause the child to stop eating and develop behavior problems that make it difficult if not impossible for the parent to feed the child. Compounding the problem, frequent avoidance of eating may contribute to failure to develop appropriate oral sensorimotor skills required for successful eating and swallowing.

Infants and children who are tube fed for extended periods of time have an especially high frequency of feeding problems. In such individuals, it is believed that there is a "critical period" for developing proper oral feeding patterns, and reflexes has passed without adequate feeding experiences. This critical period has been described as being between 6 and 7 months of age, during which acquisition of oral food consumption skill is most likely. Beyond this period oral feeding abilities may not be established or may be established with great difficulty (Babbitt, 1994).

Premature infants and those that are of very low birth weight are at very high risk for feeding disorders (Rommel, 2002; Schädler, 2007; Vohr, 2006). The underdeveloped sphincter muscle between the stomach and esophagus can cause the infant to spit up frequently during feedings. Because this is uncomfortable for the child, he or she may not want to eat. One study by Schädler and colleagues (2007) in 86 premature children describes the successful use of behavioral therapy for severe feeding disorders. However, they indicate that other conditions such as cerebral palsy, mental retardation and interaction problems, which are frequent in this population, have a significant negative impact on therapy outcomes and may require an even more intensive approach to address feeding disorders.

Disorders of the digestive system can also cause feeding problems. Examples of these types of conditions include structural or functional abnormalities of the mouth, throat, or esophagus that may result in inability to chew or swallow, or cause pain during swallowing, or result in aspiration (inhaling food or fluid into the lungs). Celiac disease, necrotizing enterocolitis, Hirschsprung disease, short bowel syndrome, pyloric stenosis, and GERD may also contribute to disordered feeding behaviors. A small, controlled study by Mathisen (1999) concluded that the presence of GERD had a significant negative impact on the energy intake of affected infants. Such infants demonstrated fewer adaptive skills and readiness behaviors for solid foods and significantly more food refusals and food loss at meal times. Christian and colleagues (2021) conducted a single-center retrospective study of infants with short bowel syndrome and concluded that the majority of infants weaned from parenteral nutrition and who demonstrated symptoms of a feeding disorder at age 2 continued to have symptoms until the age of 4.

Neurologic and neuromuscular disorders, such as cerebral palsy, are associated with significantly increased difficulty with feeding. In such children, spasticity or weakness of the oral musculature results in difficulty with oral food preparation prior to swallowing (for example, sipping, sucking, or chewing), but problems swallowing may also be present. This may progress from simple frustration to more significant problems such as aspiration and respiratory infections (Arvedson, 2008; Field, 2003; Gisel, 2008; Rogers, 2004).

Developmental disorders, such as Down syndrome and autism spectrum disorders, may also contribute to feeding problems (Manikam, 2000). While such individuals frequently have co-existing physical disorders as described above, they may also demonstrate unique behavioral issues that impair feeding (Kodak, 2008; Schreck, 2004). Food aversion and food refusal in these individuals are sometimes linked to difficulties with food texture and type which significantly limit the accepted food options for these individuals. It is important to note that feeding disorders may be comorbid with developmental disorders without being part of the developmental disorder itself. There are no developmental disorders whose diagnostic criteria include feeding disorders as defined above.

Evaluation for pediatric feeding disorders is probably best performed by a multidisciplinary team (Arvedson, 2008; Lifschitz, 2001; Rommel, 2003). Members of this team may include, but are not limited to, a pediatrician, family physician, gastroenterologist, dietitian, occupational therapist, speech-language pathologist, pediatric behavioral and developmental specialist, psychologist, and social worker. These professionals work together to assess the individual and determine the possible underlying causes for the disorder, followed by creating a treatment plan. The assessment process should evaluate a wide range of issues, including the structure and function of the mouth, upper airway, gastrointestinal tract; as well as behavioral aspects of feeding such as the parental-child interaction.

The rationale for treatment is that children whose feeding problems are treated with nasogastric, gastrostomy, or jejunostomy tubes are more likely to need therapy to become oral feeders. Placement of a feeding tube has been shown to actually cause or worsen feeding problems for many children (Crosby, 2007).

Treatment for diagnosed pediatric feeding disorders may also require a multidisciplinary team approach (Arvedson, 2008; Lifschitz, 2001; Rommel, 2003). This team should include the same types of professionals described above for the evaluation process, to treat both the causative and underlying medical conditions, as well as to provide the various interventions deemed appropriate for the treatment of the individual. Many studies have demonstrated the benefits of such a multidisciplinary approach (Benoit, 2000; Byars, 2003; Williams, 2017). Rommel and colleagues (2003) described the multidisciplinary treatment of 700 infants and young children with feeding disorders, reporting that almost 50% of the study subjects presented with a combination of medical (for example, GERD, neurologic or other problem) and oral (for example, oral motor issues, sensory problems, etc.) pathology underlying their disorder. There were also a substantial number of individuals presenting with combined oral-behavioral (for example, food avoidance, tantrums, etc.), and medical-behavioral conditions as well. These individuals were treated by a team approach, with 73.1% of the individuals experiencing significant benefits beyond 2 months to 5 years.

The use of outpatient pediatric intensive feeding programs was investigated in a small, randomized controlled trial involving 20 subjects ages 13 to 72 months (Sharp, 2016). This study investigated the feasibility and efficacy of an intensive, manual-based

behavioral feeding intervention for children with chronic food refusal and dependence on enteral feeding or oral nutritional formula supplementation. Subjects were assigned to receive treatment for 5 consecutive days in a day treatment program (n=10) or wait list (n=10). A multidisciplinary team implemented treatment and delivered parent training to support generalization of treatment gains. The primary outcome measures were bite acceptance, disruptions, and amount of food consumed during meals (in grams). Caregivers reported high satisfaction and acceptability of the intervention. The intervention group had 9 study subjects (90%) and 8 control group subjects who completed the study. The authors reported that the intervention group demonstrated significantly greater improvements from baseline ($p<0.05$) on all primary outcome measures, including bites accepted (88.9% for the intervention group vs. 5.6% controls, $p=0.008$), reduction in disruptions (55.6% vs. 9.2%, respectively; $p=0.038$), and volume of food consumed (31 g vs. -1 g, respectively; $p=0.022$). No significant change was noted for BMI measurement. A 1-month follow-up suggested stability in treatment gains.

Inpatient Programs

The effectiveness of inpatient pediatric intensive feeding programs has been evaluated in a limited number of published studies. One small retrospective case series study involved 30 subjects requiring weaning from gastrostomy tube feeding (Brown, 2014). In this study the length of inpatient stay was 19 days and subjects were followed for an average of 4 months post-hospitalization. The authors reported that the percent of goal daily calories taken by mouth increased from a mean of 22% to a mean of 92%. A total of 90% of subjects had successfully discontinued gastrostomy tube feedings at the time of discharge. No data was provided regarding gastrostomy tube use during the follow-up period. A second retrospective case series study involving 77 subjects requiring weaning from gastrostomy tube feeding was published by Silverman in 2013. In this study the mean length of stay was 10.9 days and subjects were followed for 12 months post-discharge. The caloric goal obtained via oral feeding increased from a mean of 28% at baseline to 83% at discharge. No data regarding caloric intake was provided for the follow-up period. Gastrostomy tube feeding was ceased in 51% of subjects at discharge, with another 12% ceasing during the follow-up period. Gastrostomy tubes had been removed from 14 subjects at the end of the inpatient treatment period.

The available evidence addressing the safety and efficacy of inpatient pediatric intensive feeding programs is limited. Further investigation is warranted.

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Government Agency, Medical Society, and Other Authoritative Publications:

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History

Status	Date	Action
Revised	02/15/2024	Medical Policy & Technology Assessment Committee (MPTAC) Review. Revised statement regarding treatment. Revised the note defining “duplicate treatment.” Revised the statement regarding maintenance programs. Revised formatting in Clinical Indications section. Revised References and Websites sections.
Reviewed	02/16/2023	MPTAC Review. References were updated.
Reviewed	02/17/2022	MPTAC Review. Updated Discussion, References, and Websites sections.
Reviewed	02/11/2021	MPTAC Review. Updated Discussion, References and Websites sections. Updated Coding section to add NOC 99199 when specified as services related to intensive programs for pediatric feeding disorders.
Reviewed	02/20/2020	MPTAC Review. Updated References and Websites sections.
Reviewed	03/21/2019	MPTAC Review. Updated Discussion, References and Websites sections.
Revised	05/03/2018	MPTAC Review. The document header wording updated from “Current Effective Date” to “Publish Date.” Minor typographical edits made to the Clinical Indications section. Updated References section.
Reviewed	05/04/2017	MPTAC Review. Updated formatting in Clinical Indications section. Updated Rationale and References sections.
Reviewed	05/05/2016	MPTAC Review. Updated References section. Removed ICD-9 codes from Coding section.
Reviewed	05/07/2015	MPTAC Review. Updated formatting throughout the medical necessary statements and clarified the first “Note” in the clinical indications section. Updated References section.
Reviewed	05/15/2014	MPTAC Review.
Reviewed	05/09/2013	MPTAC Review. Updated References section.
Reviewed	05/10/2012	MPTAC Review. Updated References section.
Reviewed	05/19/2011	MPTAC Review. Updated References and Coding sections.
Reviewed	05/13/2010	MPTAC Review. Updated References section.
New	05/21/2009	MPTAC initial document development.

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terms of frequency or in some other manner.