MEDICAL POLICY

POLICY TITLE	INTENSIVE PEDIATRIC FEEDING PROGRAMS
POLICY NUMBER	MP 2.079

CLINICAL BENEFIT	☒ MINIMIZE SAFETY RISK OR CONCERN. ☒ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☒ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	**10/1/2024**

I. POLICY

Multidisciplinary outpatient and intensive pediatric day feeding programs may be considered **medically necessary** for infants, children, and adolescents (21 years of age and younger) with complex feeding and swallowing disorders when **all** of the following are met:

- Patient has a significant feeding disorder associated with a medical condition. Examples include, but are not limited to:
  - Prematurity
  - Cleft palate
  - Neurologic condition (e.g. cerebral palsy, muscular dystrophy)
  - Gastrointestinal disorder (e.g. reflux, esophagitis)
  - Gastrostomy tube and need to transition to oral feedings
  - Failure to thrive
  - Behavior problems interfering with feeding
  - Food refusal/selectivity
  - Short gut syndrome
  - Oral motor dysfunction (e.g. dysphagia)
  - Self-feeding deficits
  - Developmental disorder
  - Cardiorespiratory disease
  - Feeding tube dependent; **and**
- Adequate treatment of the contributing underlying condition has occurred without resolving the feeding problem; **and**
- Patient is not responsive to treatments by a single discipline (e.g., occupational therapist, dietician, or speech language pathologist) over a 2-month period.

A feeding disorder treatment program is considered **not medically necessary** for infants, children, and adolescents 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.

These requests may be approved for two (2) to four (4) weeks at a time.

The following information may be considered to establish a plan of treatment:

- Growth charts which include height, weight, and/or body mass index (BMI); **or**
- History of treatment by the primary care physician; **or**
- List of co-morbidities and severity**; or**
- Treatment plan and estimate of duration; **or**
- Specific treatment goals.

This policy does not apply to feeding disorders related to mental health diagnoses.

Inpatient and residential pediatric feeding programs are considered **not medically necessary.**

Cross-references:

MP 2.015 Enteral Nutrition
MP 2.304 Autism Spectrum Disorders
MP 3.008 Parenteral Home Infusion Therapy (Including Total Parenteral Nutrition)
MP 8.002 Speech Therapy (Outpatient)
MP 8.004 Occupational Therapy (Outpatient)

II. PRODUCT VARIATIONS

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This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations as discussed in Section VI. Please see additional information below.

FEP PPO - Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at: https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies.

III. DESCRIPTION / BACKGROUND

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Pediatric feeding disorder (PFD) is defined by impaired oral intake that is not age-appropriate and is associated with medical, nutritional, feeding skill, and/or psychosocial dysfunction. There are many medical conditions that can lead to feeding disorders, such as 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) and anatomic or congenital abnormalities (e.g., cleft lip and/or palate). Since the publication of the World Health Organization International Classification of Functioning, Disability, and Health (ICF), there is increasing

recognition that diagnoses do not necessarily predict function, and that assessment of functional limitations is critical to planning appropriate interventions to improve quality of life.

When feeding problems continue over a long period of time, the child may not grow and may suffer from frequent illnesses. Malnutrition affects 25% to 50% of children with PFD. In addition, these problems affect a child's ability to function at home, school, and social settings, thereby creating an impact on the child's development. Examples of severe feeding problems include:

- Inability or refusal to eat;
- Severe difficulty swallowing;
- Choking, gagging, or vomiting when eating;
- Dependence on tube feedings or difficulty weaning from a gastric feeding tube (G-tube);
- Failure to thrive; and
- Severe gastroesophageal reflux.

Early intervention can deter behavioral changes and long-term eating disorders, which can affect growth and health, and can avert the need for tube feedings. Feeding disorders are fairly common in infants and toddlers, with approximately 25-35% of these children experiencing some difficulties with feeding. 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. Malnutrition is found in approximately 25-50% of children diagnosed with pediatric feeding disorder, particularly those children with chronic disease or neurodevelopmental disorder. Most of these children will respond well to suggestions offered by the nurse, nutritionist, and other specialists to parents on feeding methods, food choices, approach, and behavioral recommendations and do not require the services of a formal pediatric feeding program.

Outpatient Pediatric Feeding Programs

Pediatric Intensive Day Feeding Programs

Pediatric intensive day feeding programs are interdisciplinary programs that provide treatment for patients with impairment of oral intake. These programs combine medical and behavioral health techniques. The multidisciplinary services may include gastroenterology, behavior psychology, psychosocial family support, education, nutritional or occupational therapy and speech therapy.

These feeding programs provide intensive feeding sessions six to eight hours per day, five days per week, and include 3-5 feeding sessions per day. Between feedings, naps, school, and playroom activities are offered. The day program usually lasts between two and four weeks.

Outpatient Therapy

Outpatient programs provide treatment for children whose feeding problems require less intensive therapy (e.g., once a week). Children frequently have a special meal at the clinic where feeding and behavioral problems are addressed. The team works with the parents to assist with helpful strategies and to provide support. Caregivers report on the child's progress and practice the recommended feeding methods. The goals of these programs are to normalize the child's oral intake and to maintain and improve growth patterns.

Inpatient Feeding Programs
Inpatient programs have been used for children with severe feeding difficulties and significant medical co-morbidities so that close medical assessment, nutritional monitoring, oral motor assessment and intense behavioral intervention can be conducted under 24-hour supervision.

IV. RATIONALE

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NA

V. DEFINITIONS

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FAILURE TO THRIVE is a term used to describe children, generally up to 3 years of age, who demonstrate a downward deviation in growth when compared to expectations from the standard growth charts of the National Center for Health Statistics (NCHS) Centers for Disease Control (CDC) growth charts. Standard growth charts of the National Center for Health Statistics (NCHS) are available at: http://www.cdc.gov/growthcharts/.

FEEDING DISORDER is identified when a child is unable or refuses to eat or drink a sufficient quantity or variety of food to maintain proper nutrition.

VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits, and which require preauthorization. There are different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VII. DISCLAIMER

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Capital Blue Cross' medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Covered when medically necessary:

Procedure Codes								
G0270	G0271	S9452	S9470	92526	92610	97165	97166	97167
97168	97802	97803	97804					

ICD-10 Diagnosis Codes	Description
F98.21	Rumination disorder of infancy and childhood
F98.29	Other feeding disorders of infancy and early childhood
F98.3	Pica of infancy and childhood
G71.11	Myotonic muscular dystrophy
G80.0	Spastic quadriplegic cerebral palsy
G80.1	Spastic diplegic cerebral palsy
G80.2	Spastic hemiplegic cerebral palsy
G80.3	Athetoid cerebral palsy
G80.4	Ataxic cerebral palsy
G80.8	Other cerebral palsy
G80.9	Cerebral palsy, unspecified
K20.0	Eosinophilic esophagitis
K20.80	Other esophagitis without bleeding
K20.81	Other esophagitis with bleeding
K20.90	Esophagitis, unspecified without bleeding
K20.91	Esophagitis, unspecified with bleeding
K21.00	Gastro-esophageal reflux disease with esophagitis, without bleeding
K21.01	Gastro-esophageal reflux disease with esophagitis, with bleeding
K21.9	Gastro-esophageal reflux disease without esophagitis
K90.9	Intestinal malabsorption, unspecified
P07.20	Extreme immaturity of newborn, unspecified weeks of gestation
P07.21	Extreme immaturity of newborn, gestational age less than 23 completed weeks
P07.22	Extreme immaturity of newborn, gestational age 23 completed weeks
P07.23	Extreme immaturity of newborn, gestational age 24 completed weeks
P07.24	Extreme immaturity of newborn, gestational age 25 completed weeks
P07.25	Extreme immaturity of newborn, gestational age 26 completed weeks

ICD-10 Diagnosis Codes	Description
P07.26	Extreme immaturity of newborn, gestational age 27 completed weeks
P07.30	Preterm newborn, unspecified weeks of gestation
P07.31	Preterm newborn, gestational age 28 completed weeks
P07.32	Preterm newborn, gestational age 29 completed weeks
P07.33	Preterm newborn, gestational age 30 completed weeks
P07.34	Preterm newborn, gestational age 31 completed weeks
P07.35	Preterm newborn, gestational age 32 completed weeks
P07.36	Preterm newborn, gestational age 33 completed weeks
P07.37	Preterm newborn, gestational age 34 completed weeks
P07.38	Preterm newborn, gestational age 35 completed weeks
P07.39	Preterm newborn, gestational age 36 completed weeks
P78.83	Newborn esophageal reflux
P92.6	Failure to thrive in newborn
P92.8	Other feeding problems of newborn
P92.9	Feeding problem of newborn, unspecified
Q35.1	Cleft hard palate
Q35.3	Cleft soft palate
Q35.5	Cleft hard palate with cleft soft palate
Q35.7	Cleft uvula
R13.10	Dysphagia, unspecified
R13.11	Dysphagia, oral phase
R13.12	Dysphagia, oropharyngeal phase
R13.13	Dysphagia, pharyngeal phase
R13.14	Dysphagia, pharyngoesophageal phase
R13.19	Other dysphagia
R62.51	Failure to thrive (child)
R63.30	Feeding difficulties, unspecified
R63.31	Pediatric feeding disorder, acute
R63.32	Pediatric feeding disorder, chronic
R63.39	Other feeding difficulties
R63.4	Abnormal weight loss
R63.6	Underweight
R63.8	Other symptoms and signs concerning food and fluid intake
Z93.1	Gastrostomy status

IX. REFERENCES

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IX. POLICY HISTORY

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MP 2.079	**03/27/2020 Consensus Review**. No changes to the policy statements. References reviewed.
	07/07/2020 Administrative Update. No changes to policy statement. Added HCPCs codes S9452, S9470.
	09/02/2020 Administrative Update. ICD 10 codes added, K20.80, K20.81, K20.90, K20.91, K21.00, K21.01
	08/26/2021 Consensus Review. Policy statement language clarification: “infants and children” revised to “infants, children and, adolescents (21 years of age and younger)”. References added and updated.
	09/07/2021 Administrative Update. New ICD-10 codes added, effective 10/1/2021
	02/03/2022 Minor Review. Modified first policy statement bullet point to state "Patient has a significant feeding disorder associated with a medical condition. Examples include but are not limited to". Added developmental disorder and cardiorespiratory disease to medical conditions. Added statement that feeding disorder treatment is not medically necessary for picky eaters or selective eating behaviors when growth and developmental milestones are met. Included statement that policy does not apply to feeding disorders related to mental health diagnoses. Product variation statement updated and FEP language included. Background revised. Removed ICD10 code R63.3. References added.
	02/23/2023 Consensus Review. No change to policy statement. References reviewed and updated. Coding reviewed.
	01/26/2024 Consensus Review. No change to policy statement. References reviewed and updated. Coding reviewed.

	08/16/2024 Administrative Update. Revised description of ICD-10 code F98.21, effective 10/1/2024.

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