



**ORAL FUNCTION THERAPY  
FOR PEDIATRIC FEEDING DISORDERS  
HS-188**



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**Oral Function Therapy for  
Pediatric Feeding Disorders**

**Policy Number: HS-188**

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**DISCLAIMER**

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

**APPLICATION STATEMENT**

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

**BACKGROUND**

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

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

The term "feeding disorder" refers to a condition in which a patient 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.

Feeding disorders may result from a wide range of causes, including medical conditions (e.g., food allergies, neurologic or neuromuscular disease, gastroesophageal reflux, and others), structural or functional abnormalities (e.g., defects of the palate), or behavioral issues (e.g., 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.

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.

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 (e.g., 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.

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 patient. Many studies have demonstrated the benefits of such a multidisciplinary approach (Benoit, 2000; Byars, 2003). 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 (e.g., GERD, neurologic or other problem) and oral (e.g., oral motor issues, sensory problems, etc.) pathology underlying their disorder. There were also a substantial number of patients presenting with combined oral-behavioral (e.g., food avoidance, tantrums, etc), and medical-behavioral conditions as well. These patients were treated by a team approach, with 73.1 % of the patients experiencing significant benefits beyond 2 months to 5 years.

## **POSITION STATEMENT**

### **Evaluation of Children Whose Difficulties Began Under Five Years of Age**

**An evaluation to confirm a suspected diagnosis of pediatric feeding disorder is considered medically necessary when EITHER of the following criteria are met:**

- Failure to meet developmental milestones of growth and development, including either of the following:
  - Significant weight loss or reduction or cessation of weight gain over the previous 2 months; **OR**,
  - Crossing 2 or more major weight percentiles downward

**OR,**

- Growth and development milestones have been met, but only via nutritional support consisting of high-calorie foods, nutritionally deficient foods, or both, and the transition to nutritionally and calorically-appropriate foods is warranted

### **Evaluation of Children of Any Age**

**An evaluation to confirm a suspected diagnosis of pediatric feeding disorder is considered medically necessary when EITHER of the following criteria are met:**

- 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:
  - Reduction or cessation of weight gain over the previous 2 months; **OR**,
  - Crossing 2 or more major weight percentiles downward

**OR,**

- Significant change in feeding behavior is felt to be compromising the child's nutritional status, including either of the following:
  - Reduction or cessation of weight gain over the previous 2 months; **OR**,
  - Crossing 2 or more major weight percentiles downward

### Nature of the Evaluation

The evaluations above should include:

- A thorough medical evaluation including neurologic, metabolic, and gastrointestinal (specifically malabsorption and gastroesophageal reflux disease), clinical nutrition work-up as indicated; **AND**,
- An evaluation to identify any structural or functional abnormalities; **AND**,
- An evaluation of possible behavioral components

### Reevaluation

A reevaluation **is considered medically necessary** when any of the following occur:

- New clinical findings; **OR**,
- A rapid change in member's status; **OR**,
- Failure to respond to therapy interventions

### Treatment

The treatment of a pediatric feeding disorder **is considered medically necessary** when such a disorder has been diagnosed after the appropriate evaluation and ALL of the following criteria are met:

- A thorough medical evaluation, as described above, has been completed; **AND**,
- Adequate treatment for any contributing underlying medical conditions, if present, has occurred without resolution of the feeding problem; **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

### Progress Toward Goals

Assessment of progress toward goals should be made on a regular basis, approximately every 4–6 weeks. Goals should be re-evaluated and may be revised depending on progress and the member's condition.

### Not Medically Necessary

Evaluation and treatment for pediatric feeding disorders **are considered NOT medically necessary** when the criteria above are not 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 (e.g., 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**. When members receive concurrent physical, occupational, behavioral, or speech therapy, the therapists should provide different treatments that reflect each

therapy discipline's unique perspective on the member's impairments and functional deficits and not duplicate the same treatment. They must also have separate evaluations, treatment plans, and goals.

Maintenance programs **are considered not medically necessary**. A maintenance program consists of treatments or activities that preserve the member'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

### CPT® Codes

- 92526 Treatment of swallowing dysfunction and/or oral function for feeding
- 92610 Evaluation of oral and pharyngeal swallowing function
- 92611 Motion fluoroscopic evaluation of swallowing function by cine or video recording
- 92612 Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording
- 92613 Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording
- 92616 Flexible fiberoptic endoscopic evaluation of swallowing & laryngeal sensory testing by cine or video recording
- 92617 Flexible fiberoptic endoscopic evaluation of swallowing & laryngeal sensory testing by cine or video recording physician interpretation & report only.
- 92700 Flexible fiberoptic or endoscopic evaluation of swallowing without cine or video recording

### ICD-9-CM Procedure Codes

- 31.42 Laryngoscopy
- 87.61 Barium Swallow

HCPSC Level II® Codes - No applicable codes

### Covered ICD-9-CM Diagnosis Codes

- 783.1 Abnormal weight gain
- 783.21 Abnormal weight loss
- 783.3 Feeding difficulties (pediatric; child)
- 783.41 Failure to gain weight

\*Current Procedural Terminology (CPT) 2011 American Medical Association: Chicago, IL.©

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**Government Agencies, Professional and Medical Organizations**

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**HISTORY AND REVISIONS**

| <b>Date</b> | <b>Action</b>  |
|-------------|--|
| 12/1/2011   | <ul style="list-style-type: none"><li>• New template design approved by MPC.</li></ul> |
| 9/1/2011    | <ul style="list-style-type: none"><li>• Approved by MPC.</li></ul>                     |