Easy Choice Health Plan

Missouri Care

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona

OneCare (Care1st Health Plan Arizona, Inc.)

Staywell of Florida

WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

WellCare Prescription Insurance

WellCare Texan Plus (Medicare – Dallas & Houston markets)

Oral Function Therapy for Feeding Disorders

Policy Number: HS-188

Original Effective Date: 9/2/2010

Revised Date(s): 9/1/2011; 9/6/2012; 9/5/2013; 9/4/2014; 7/9/2015; 7/7/2016; 9/27/2016; 6/1/2017; 5/3/2018

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.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). 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 CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

BACKGROUND

Sources: Gisel, 2008; Kodak & Piazza, 2008; American Speech-Language-Hearing Association, 2002.

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.[1,2]
Possible situations that could initiate an evaluation for a pediatric feeding disorder include:[3]

- Back arching;
- Breathing difficulties when feeding that might be signaled by

  - Increased respiratory rate during feeding,
  - Skin color change such as turning blue,
  - Apnea,
  - Stopping frequently due to uncoordinated suck-swallow-breathe pattern,
  - Desaturation (decreasing oxygen saturation levels);
  - Changes in normal heart rate (brachycardia or tachycardia) in association with feeding;
- Coughing and/or choking during or after swallowing;
- Crying during mealtimes;
- Decreased responsiveness during feeding;
- Dehydration;
- Difficulty chewing foods that are texturally appropriate for age (may spit out partially chewed food);
- Difficulty initiating swallowing;
- Difficulty managing secretions (including non-teething related drooling of saliva);
- Disengagement cues, such as facial grimacing, finger splaying, or head turning away from food source;
- Frequent congestion, particularly after meals;
- Frequent respiratory illnesses;
- Gagging;
- Loss of food/liquid from the mouth when eating;
- Noisy or wet vocal quality noted during and after feeding;
- Prolonged feeding times;
- Refusing foods of certain textures or types;
- Taking only small volumes, over-packing the mouth, and/or pocketing foods;
- Vomiting (more than typical "spit up" for infants);
- Weight loss or lack of appropriate weight gain

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), behavioral issues (e.g., crying or tantrums that prevent successful completion of mealtimes), or developmental disabilities (e.g. disability prior to 22 months of age). Feeding disorders can also be a result of medication side effects or environmental issues such as parent-child conflicts at meal time. In most cases, there is likely a complex interaction among multiple causative factors. 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 entercolitis, Hirschprung disease, short bowel syndrome, pyloric stenosis, and GERD may also contribute to disordered feeding behaviors. [1,2,3]

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), problems swallowing may also be present. This may progress from simple frustration to more significant problems such as aspiration and respiratory infections. [1,2]

Long term dysphagia can result in poor weight gain and malnutrition, as well as dehydration. The child may develop worsening food or oral aversion or rumination disorder (unintentional regurgitation of undigested food). Aspiration pneumonia or compromised airway could occur or the child could develop the need for enteral or parenteral nutrition.[3]

POSITION STATEMENT

Applicable To:

- ☑ Medicaid – excluding Florida**
- ☑ Medicare

** Refer to *Florida EPSDT Therapy: HS-260* for criteria related to Speech Therapy.

Exclusions

Evaluation and treatment for pediatric feeding disorders **are considered not medically necessary** when the criteria below 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 below 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.

Adult

Swallowing / Feeding Therapy for adults **is considered medically necessary** when the following criteria are met:

- The swallowing or feeding disorder is the result of an underlying medical condition; **AND**
- The medical necessity of the therapy has been demonstrated by results of testing with a videofluorographic swallowing study (VFSS) or other appropriate testing in combination with an evaluation by a certified speech-language pathologist; **AND**
- Therapy plan includes specific tests and measures that will be used to document significant progress; **AND**
- Meaningful improvement is expected from the therapy; **AND**
- Treatment includes a transition from one-to-one supervision to an individual or caregiver provided maintenance level on discharge.

Therapy Limits

There is a limit of 12 weeks for therapy services. The number of weekly visits will be based on the severity of the feeding disorder:

- 1 visit per week for mild dysfunction
- 2 visits per week for moderate dysfunction
- 3 visits per week for severe dysfunction

Pediatric

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

Therapy Limits

There is a limit of 12 weeks for therapy services. The number of weekly visits will be based on the severity of the feeding disorder:

- 1 visit per week for mild dysfunction
- 2 visits per week for moderate dysfunction
- 3 visits per week for severe dysfunction

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.

CODING

Covered 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 endoscopic evaluation of swallowing by cine or video recording
92613 Flexible endoscopic evaluation of swallowing by cine or video recording; interpretation & report only
92616 Flexible endoscopic evaluation of swallowing & laryngeal sensory testing by cine or video recording
92617 Flexible endoscopic evaluation of swallowing & laryngeal sensory testing by cine or video recording interpretation & report only.
92700 Unlisted otorhinolaryngological service or procedure

HCPCS Level II®*Codes – No applicable codes.

Covered ICD-10-PCS Codes

0CJS4ZZ Med/Surgical, Mouth and Throat, Inspection, Larynx, Percutaneous Endoscopic
0CJS8ZZ Med/Surgical, Mouth and Throat, Inspection, Larynx, Via Natural or Artificial Opening, Endoscopic
BD11YZZ Imaging, Gastrointestinal system, fluoroscopy, Esophagus, Other Contrast

Covered ICD-10-CM Diagnosis Codes

R62.51 Failure to thrive (child)
R62.7 Adult failure to thrive
R63.3 Feeding difficulties
R63.4 Abnormal weight loss
R63.5 Abnormal weight gain

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES

1. Kodak T, Piazza CC. Assessment and behavioral treatment of feeding and sleeping disorders in children with autism spectrum disorders. *Child & Adolescent Psychiatric Clinics of North America.* 2008;17(4):887-905.
2. Position statement: roles of speech-language pathologists in swallowing and feeding disorders. American Speech-Language-Hearing Association Web site. http://www.asha.org/policy/PS2002-00109.htm. (Rescinded March 2014) Accessed April 11, 2018.
3. Position statement: pediatric dysphagia. American Speech-Language-Hearing Association Web site. http://www.asha.org/PRPSpecificTopic.aspx?folderid=8589934965§ion=Assessment. Accessed April 11, 2018.

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	Action
5/3/2018	• Approved by MPC. No changes.
6/1/2017	• Approved by MPC. Added additional verbiage from updated reference.
9/27/2016	• Approved by MPC. No changes.
7/9/2015	• Approved by MPC. Now includes Adult criteria and therapy limits.
9/4/2014, 9/5/2013, 9/6/2012	• Approved by MPC. No changes.
12/1/2011	• New template design approved by MPC.
9/1/2011	• Approved by MPC.