KAISER PERMANENTE® Mid-Atlantic States	**Pediatric Feeding Disorder Therapy** **Medical Coverage Policy**

Utilization *ALERT*

- Prior to use of this MCP for evaluation of medical necessity, benefit coverage MUST be verified in the member's EOC or appropriate benefit document.
- For Medicare members, please refer to CMS guidelines through Medicare Coverage Database requirements.
- Note: After searching the Medicare Coverage Database, if no NCD/LCD/LCA is found, then use the policy referenced above for coverage guidelines

I. Service or Procedure: **Pediatric Feeding Disorder (PFD) Therapy**

II. Specialty: Behavioral therapy, Nutritional therapy, Rehabilitation therapy

III. Clinical Indication for Referral

Feeding disorders among infants and children are not like eating disorders which are usually observed in adolescence and adulthood such as anorexia and bulimia.

PFD typically begins under the age of 5. The disorder has a profound physiologic and functional impact on the physical, social, emotional, and/or cognitive function of the infant or child. It is often caused by a combination of factors (medical, behavioral, socio- emotional or combination) within these general categories:

1. Structural abnormalities of the face, oral cavity, or aero-digestive system.
2. Developmental delays or developmental disabilities
3. Neuro-muscular dysfunction or lack of coordination.
4. Inadequate strength and/or rapid fatigue or lack of endurance.
5. Inability to coordinate, suck/swallow/breathe normally because of respiratory distress; and
6. Pain or discomfort during the feeding process

IV. Evaluation

A. 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 the following criteria:

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

B. 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:
   1. 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:
      a. Reduction or cessation of weight gain over the previous 2 months; **or**
      b. Crossing 2 or more major weight percentiles downward; **or**

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

C. **Evaluation**

   ***** Evaluation for PFD should include **ALL** of the following:
   1. A thorough medical evaluation including specialist evaluation when indicated - neurologic, metabolic, and gastrointestinal (specifically evaluation for malabsorption and gastroesophageal reflux disease by a qualified pediatric gastroenterologist; ***and***
   2. A formal nutritional evaluation that documents deficiencies; **and**
   3. An evaluation to identify any structural or functional abnormalities; ***and***
   4. An evaluation of possible behavioral components.

D. Conditions that could warrant PFD evaluation

   † Situations that could initiate an evaluation for a pediatric feeding disorder include:
   1. Child coughs, chokes, or gags while eating or immediately after eating; **or**
   2. Child demonstrates a history of chronic pulmonary difficulties which may include diagnosis of aspiration pneumonia; **or**
   3. Vocal cord dysfunction; **or**
   4. Food is being suctioned out of the child's airway; **or**
   5. Weight gain is poor and difficult, and this is thought to be secondary to an oral, pharyngeal, or swallowing dysfunction; **or**
   6. Difficulty initiating a swallow; **or**
   7. Structural abnormalities are present that may interfere with the development of a normal swallow; **or**
   8. Neuromotor involvement affecting oral-sensorimotor coordination and respiration; **or**
   9. Chronic poor growth or compromised nutritional status; **or**
   10. Difficulties transitioning from tube or gastrostomy tube feedings to oral feedings.

V. Re-evaluation

A. A ***re-evaluation*** is considered **medically necessary** when there are **any** of the following:
   1. New clinical findings; **or**
   2. A rapid change in individual's status; **or**
   3. Failure to respond to therapy interventions (for example, speech and language, occupational therapy, physical, and behavioral therapy).

B. Components of Re-evaluation

There are several routine reassessments that are not considered re-evaluations. These include ongoing reassessments that are part of each skilled treatment session, progress reports, and discharge summaries. Re-evaluation is a more comprehensive assessment that usually includes the components of the initial evaluation, and may also include components such as the following:

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

VI. Treatment

A. The ***treatment*** of a pediatric feeding disorder is considered **medically necessary** when such a disorder has been diagnosed after appropriate evaluation and ALL of the following criteria are met:
   1. A thorough medical evaluation, as described above, has been completed; **and**
   2. Adequate treatment for any contributing underlying medical conditions, if present, has occurred without resolution of the feeding problem; **and**
   3. 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.

B. 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 have not been met.

VII. Re-evaluation of Feeding Therapy

An **intensive pediatric feeding therapy program** consists of a multi-disciplinary team with a diagnosis-specific treatment plan, child-specific interventions, and projected estimate of the length of treatment, as detailed in the therapeutic goal of the program.

A. The infant or child's progress with the feeding program should be re-evaluated on a regular basis, at approximately every 4-6 weeks, to determine if therapeutic goals are being met and to reassess if continuity of treatment would be needed or revision of the goal of therapy will be warranted.

B. Re-assessment of the child's condition in addition to routine evaluation of the program is required in the presence of the following:
   1. A sudden change in the child's status; or
   2. New clinical findings; or
   3. Failure to respond to therapeutic interventions (i.e., speech and language, occupational, behavioral, and physical)

VIII. Limitations

A. The guidelines addressed in this policy are limited to infants and children and not applicable to adults; *and*

B. A feeding therapy program is limited to a maximum of 12 weeks. The required number of weekly visits is based on the severity or complexity of the feeding disorder as follows:
   1. 1 visit per week for mild dysfunction; or
   2. 2 visits per week for moderate dysfunction; or
   3. 3 visits per week for severe dysfunction

IX. Exclusion

Feeding therapy is considered **NOT medically necessary** for the following as efficacy of treatment for these conditions have not been established:

A. Childhood obesity without another medical diagnosis (i.e., autism);

B. Eating habits or feeding patterns that are exclusively behavior-related, does not have an underlying medical condition, can eat and swallow normally and able to meet the normal growth and developmental milestones such as:
   1. Food aversion.
   2. Food neophobia;
   3. Oral aversion;
   4. "Picky/fussy" eating;
   5. Taking too long to eat;
   6. Inappropriate behavior during mealtime;
   7. Refusal to feed oneself; or

8. Selective eating behavior based on type, smell or texture of food or liquids
   Note:
   Introduction of greater selection and variety of food and liquids with the objective of lesser food rejection is considered behavioral training and not feeding therapy.

C. Improvement from therapy is not expected to occur based on the patient's diagnosis.

D. Maintenance feeding program.

E. Duplicate therapy; or

F. Hospitalization for pediatric intensive feeding program **except** when inpatient care is required due to acute medical complications of the feeding disorder such as but not limited to the following:
   1. Serious medical problems as a result of the feeding disorder;
   2. Severe nutritional deficiencies;
   3. Severe dehydration and/or electrolyte imbalance;
   4. Failure to respond to several months of out-patient intensive feeding management;
   5. Major difficulty transitioning from parenteral or enteral feeding to oral feeding; or
   6. Potential serious allergic food reaction

X. Definition

Pediatric feeding disorder therapy is a therapeutic team-approach program for infants and children to treat complex feeding and swallowing disorders, that is led and coordinated by a physician with a team of multi-disciplinary healthcare professionals such as speech-language pathologist/therapist, behavioral therapist, psychologist, social worker, occupational therapist, physical therapist, nurse, and registered dietitian.

Pediatric feeding disorders (PFD), also called **avoidant/restrictive food intake disorder** are a set of conditions where an infant or a child is unable, has difficulty, avoids, or refuses to eat sufficient food or liquids, which may or may not include problems with swallowing. As a result, PFD has a physiological and functional impact on the infant or child. It leads to significant nutritional deficiencies, weight loss or poor or failure to gain weight, feeding-skill dysfunction; difficulties in family and community life & participation in daily social activities and inability to reach the expected or optimal growth and developmental milestones

Maintenance feeding programs are services which consist of repetitive treatments or activities, designed to preserve the child's current parameter level (such as strength, function, coordination, balance, etc.) when the therapeutic goals of the feeding treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

Duplicate therapy is the provision of therapeutic services (physical, occupational, behavioral, or speech

therapy) in concurrent with other therapies that do not reflect the discipline's unique perspective on the child's impairment and functional deficit, nor provide a well-defined therapeutic goals and plan, distinct treatments nor separate evaluation from other therapies.

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Approval History

Effective June 01, 2016, state filing is no longer required per Maryland House Bill HB 798 – Health Insurance – Reporting

Date approved by RUMC	Date of Implementation
09/27/2021	09/27/2021
08/31/2022	08/31/2022
07/25/2023	07/25/2023
07/24/2024	07/24/2024

*****The Regional Utilization Management Committee received delegated authority in 2011 to review and approve designated Utilization Management and Medical Coverage Policies by the Regional Quality Improvement Committee.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any particular set of circumstances for an individual member.

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