JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Medical Policy Manual** **Medical Policy**	*Policy Number*	CMS16.15
		Effective Date	04/01/2024
		Approval Date	01/16/2024
	Subject **Pediatric Feeding Programs**	*Supersedes Date*	05/01/2023
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This document applies to the following Participating Organizations:

Advantage MD	EHP	Johns Hopkins Health Plan of Virginia Inc. (JHHPVA)	Priority Partners
US Family Health Plan			

Keywords: Feeding Disorders, Feeding Program, Intensive Feeding

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I. ACTION

	New Policy	
X	Revising Policy Number	CMS16.15
	Superseding Policy Number	
	Retiring Policy Number	

II. POLICY DISCLAIMER

Johns Hopkins Health Plans (JHHP) provides a full spectrum of health care products and services for Advantage MD, Employer Health Programs, Johns Hopkins Health Plan of Virginia Inc., Priority Partners, and US Family Health Plan. Each line of business possesses its own unique contract, benefits, regulations, and regulators' clinical guidelines that supersede the information outlined in this policy.

III. POLICY

For Advantage MD refer to: Medicare Coverage Database

- No Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) identified, (Accessed 1/4/2024)

For Employer Health Programs (EHP) refer to:

- Plan specific Summary Plan Descriptions (SPDs)

For Johns Hopkins Health Plan of Virginia LLC (JHHPVA) refer to: Medicare Coverage Database

- No Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) identified, (Accessed 1/4/2024)

For Priority Partners (PPMCO) refer to: Code of Maryland Regulations

- Code of Maryland Regulations (COMAR)10.67.06.20 EPSDT Services

For US Family Health Plan (USFHP) refer to: Tricare Policy Manuals

- TRICARE Policy Manual 6010.63-M, April 1, 2021, Chapter 7, Section 3.14 Eating Disorder Treatment

IV. POLICY CRITERIA

A. This policy addresses the evaluation and treatment of Pediatric Feeding Disorders, which are defined as conditions wherein a child is unable or refuses to eat a sufficient quantity or variety of food to maintain normal nutrition, growth and physical development. It does not apply to treatment of eating disorders (i.e., anorexia or bulimia). Common medical diagnoses for children admitted to the program include but are not limited to: pulmonary disease, autism spectrum disorder, gastrointestinal disease including G-tube dependence, history of prematurity, and developmental delay. This policy specifically defines criteria for Pediatric Intensive Feeding Programs for evaluation and for admission.

B. When benefits are provided under the member's contract, JHHP considers an evaluation medically necessary to determine whether a primary pediatric feeding disorder is present for children (age range from 1 to 18 years old) who are not meeting expected growth and physical developmental milestones or are undernourished/ malnourished, including children whose weight and growth parameters are altered due to highly selective and restrictive feeding patterns.
Note: Feeding Disorders include children not limited only by failure to meet expected growth parameters but may be at established norms for growth and/or exceed those norms by consuming an extremely limited variety of foods, usually high carbohydrate and high fat foods.
    1. The request for evaluation must include ALL of the following:
        a. Medical evaluation for underlying causes of the growth disturbance, AND;
        b. Documentation of previous medical and behavioral interventions.

C. When benefits are provided under the member's contract, JHHP considers admission to an intensive feeding day program medically necessary only when all of the following criteria are met:
    1. The medical evaluation supports the need for the feeding program, AND;
    2. Adequate treatment for contributing underlying medical conditions has been documented, AND;
    3. A detailed treatment plan is provided, individualized for the child, along with an estimated length of treatment, AND;
    4. Elements of behavioral and psychiatric contribution have been addressed, AND;
    5. Clinical documentation supporting significant progress toward treatment goals is required to determine the medical necessity for continuation of a pediatric intensive multidisciplinary feeding day program.
    Note: For PPMCO, behavioral health services are covered by the State-contracted Behavioral Health Administrative Service Organization (ASO).

D. When benefits are provided under the member's contract, JHHP considers intensive inpatient feeding programs an intervention of last resort. To establish the medical necessity of an intensive inpatient feeding program, ALL of the following must be provided:
    1. Documentation of all home, community and outpatient interventions, AND;
    2. Documentation of severity of condition requiring inpatient intensive multidisciplinary feeding program, including:
        a. Nutritional status of member is severely impaired, AND/OR;

b. Severe feeding difficulties that require 24-hour nursing, medical supervision or fluid intake, AND;

3. Documentation of comprehensive psychosocial evaluation demonstrating parental/caregiver adherence to prior interventions, AND;
4. All of the requirements outlined in C above have been met.

E. Unless specific benefits are provided under the member's contract, JHHC considers intensive treatment for pediatric feeding disorders not medically necessary if, in the absence of markedly abnormal/restrictive diets, growth, physical development and nutrition parameters are within normal limits.

V. DEFINITIONS

Pediatric Intensive Feeding Program: A comprehensive intensive feeding program for children ranging from toddlers to adolescents. It is a multidisciplinary team of pediatric gastroenterologists, well trained pediatricians, nurse practitioners, nurses, psychologists, occupational therapists, speech and language pathologists, dietitians, and social workers who develop personalized goals for each child (Wingert). Feeding Day Programs may be six-eight weeks in length and children receive three treatment meals per day.

VI. CODING DISCLAIMER

Note: The following CPT/HCPCS codes are included below for informational purposes and may not be all inclusive. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member's specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right or reimbursement or guarantee of payment. Other policies and coverage determination guidelines may apply.

Note: All inpatient admissions require pre-authorization.

Adherence to the provision in this policy may be monitored and addressed through post payment data analysis and/or medical review audits
Advantage MD: Regulatory guidance supersedes JHHP Medical Policies. If there are no statutes, regulations, NCDs, LCDs, or LCAs, or other CMS guidelines, apply the Medical Policy criteria.
Employer Health Programs (EHP): Specific Summary Plan Descriptions (SPDs) supersedes JHHP Medical Policy. If there are no criteria in the SPD, apply the Medical Policy criteria.
Johns Hopkins Health Plan of Virginia Inc. (JHHPVA): Regulatory guidance supersedes JHHP Medical Policies. If there are no statutes, regulations, NCDs, LCDs, or LCAs, or other CMS guidelines, apply the Medical Policy criteria.
Priority Partners (PPMCO): Regulatory guidance supersedes JHHP Medical Policy. If there are no criteria in COMAR regulations, or other State guidelines, apply the Medical Policy criteria.
US Family Health Plan (USFHP): Regulatory guidance supersedes JHHP Medical Policy. If there are no TRICARE policies, or other regulatory guidelines, apply the Medical Policy criteria.

VII. CODING INFORMATION

CPT® CODES ARE FOR INFORMATIONAL PURPOSES ONLY	
CPT®	**Description**
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision-making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
90791	Psychiatric diagnostic evaluation
90832	Psychotherapy, 30 minutes with patient
90834	Psychotherapy, 45 minutes with patient
90837	Psychotherapy, 60 minutes with patient
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92521	Evaluation of speech fluency (eg, stuttering, cluttering)
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92610	Evaluation of oral and pharyngeal swallowing function
97150	Therapeutic procedure(s), group (2 or more individuals)
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.

ICD10 CODES ARE FOR INFORMATIONAL PURPOSES ONLY	
ICD-10	**DESCRIPTION**
F50.82	Avoidant/restrictive food intake disorder

F50.89	Other specified eating disorder
F50.9	Eating disorder, unspecified
F98.29	Other feeding disorders of infancy and early childhood
J69.0	Pneumonitis due to inhalation of food or vomitus (aspiration pneumonia)
R62.51	Failure to thrive (child)
R13.10	Dysphagia (difficulty in swallowing), unspecified
R63.30	Feeding difficulties, unspecified
R63.31	Pediatric feeding disorder, acute
R63.32	Pediatric feeding disorder, chronic
R63.39	Other feeding difficulties

VIII. BACKGROUND

Pediatric feeding disorders (PFD) affect up to 5% of infants and toddlers and up to 70% of children with chronic medical conditions. Feeding disorders can present with many different signs and symptoms. In some instances, they are easily identified, while others are more challenging, particularly in the presence of normal growth. If pediatric feeding disorders are unrecognized, they can result in severe consequences including compromised immune system, chronic aspiration, growth failure and death. Therefore, early identification and intervention are critical (Alexander, 2021). The causes and associations of feeding issues in infancy and early childhood are widely diverse and almost all feeding problems are multifactorial. A feeding problem is recognized when a child is not progressing through the typical course of steps to independent feeding of table foods. Some children have difficulty at birth, others struggle to move forward in accepting a variety of tastes and textures and sometimes children show regression or sudden change in their feeding skills (Borowitz, 2018).

Although there are several different ways to categorize the medical conditions that predispose infants and young children to having difficulties feeding, in most cases these conditions interfere with a child's ability to perform the activities of feeding as a result of: structural abnormalities of the face, oral cavity, or aerodigestive system; neuromuscular dysfunction/incoordination; inadequate strength and/or rapid fatigue/lack of endurance; inability to coordinate suck/swallow/breathe normally as a result of respiratory distress; and nausea and/or discomfort during the feeding process (Borowitz, 2018).

Armellino (2021) describes a consensus definition of PFD, which recognizes functional impairment in the diagnosis of PFD, based upon the World Health Organization International Classification of functioning, disability, and health. The new consensus definition of PFD is defined as the impaired oral intake that is not age-appropriate, and is associated with at least one dysfunctional domain: medical, nutritional, feeding skill, and psychosocial. The new definition allows for a unified and consistent approach to identifying patients affected by PFD.

Because of the interaction between these four domains, medical, nutritional, feeding skills, and psychosocial, impairment in one can lead to dysfunction in any of the others. The result is PFD (Goday, 2019).

The domain for medical dysfunction is described as the presence of cardiopulmonary compromise or aspiration (e.g. supplemental oxygen, recurrent pneumonia, or tracheostomy dependence). The nutritional domain is defined by Z scores for height and weight and use of enteral feeding. Use of modified feeding strategies and the presence of gagging, choking, or coughing while feeding defines the feeding domain. The psychosocial domain is characterized by developmental delay and behavioral issues with eating (Goday; Alexander, 2021).

The large majority of feeding problems in otherwise normal children are self-limited and do not require the intervention of an intensive feeding program. Children learn to adapt to new foods and feeding patterns and parents adopt strategies that do not reinforce the problems. When the feeding problem is severe or complex, medical conditions have been adequately treated, and initial treatment efforts by a single discipline (e.g., occupational therapist, speech language pathologist) have failed, evaluation within a multi-disciplinary intensive feeding program may be appropriate. A multidisciplinary team approach is recommended to monitor the nutritional status of neurologically impaired children by the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition (NASPGHAN). "Early involvement by a multidisciplinary team of physicians, nurses, dietitians, occupational and speech therapists, psychologists, and social workers is essential to prevent the adverse outcomes associated with feeding difficulties and poor nutritional status. Careful evaluation and monitoring of severely disabled children for nutritional problems is warranted because of the increased risk of nutrition-related morbidity and mortality" (Marchand, 2006). Another organization in support of the multidisciplinary approach to the treatment of pediatric feeding disorders, is the International Association of Pediatric Feeding and Swallowing (IAPFS). The association's mission is "To foster advocacy, research, collaboration, knowledge dissemination and support for interdisciplinary practice, in order to promote the highest standards of care for infants, children and adolescents with feeding disorders"(IAPFS, 2021).

Most intensive feeding programs consist of multi-specialty teams with pediatric gastroenterologists, dietitians, behavioral therapists, speech and swallowing therapists, occupational therapists, and psychologists. There are both outpatient day programs and inpatient programs.

IX. REFERENCE STATEMENT

Analyses of the scientific and clinical references cited below were conducted and utilized by the Johns Hopkins Health Plans (JHHP) Medical Policy Team during the development and implementation of this medical policy. The Medical Policy Team will continue to monitor and review any newly published clinical evidence and revise the policy and adjust the references below accordingly if deemed necessary.

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XI. APPROVALS

Historical Effective Dates: 06/28/2007, 09/08/2008, 01/07/2011, 03/07/2014, 03/04/2016, 03/02/2018, 11/02/2020, 05/02/2022, 05/01/2023, 04/01/2024