JOHNS HOPKINS HEALTHCARE

Medical Policy: Evaluation and Treatment of Pediatric Feeding Disorders
Department: Health Services
Lines of Business: EHP, USFHP, PPMCO, ADVANTAGE MD

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ACTION:
☐ New Policy
☐ Revising Policy Number
☐ Superseding Policy Number
☒ Archiving Policy Number: CMS16.15
☐ Retiring Policy Number

Effective Date: 06/28/2007
Review Dates: 09/08/08, 01/07/11, 03/07/14, 03/04/16, 03/02/18

Johns Hopkins HealthCare LLC (JHHC) provides a full spectrum of health care products and services for Employer Health Programs, Priority Partners, Advantage MD, and US Family Health Plan. Each line of business possesses its own unique contract and guidelines which, for benefit and payment purposes, should be consulted to know what benefits are available for reimbursement. Specific contract benefits, guidelines or policies supersede the information outlined in this policy.

ACTIVE AND ARCHIVED

This document has been archived as of 03/04/2016 and is no longer scheduled for review for either one or more of the following reasons:

1. This document is either primarily administrative in nature AND/OR
2. It addresses operational issues only AND/OR
3. It is mandated by statute or regulation AND/OR
4. It is unlikely that further published literature would change the determination

ARCHIVED POLICIES REMAIN ACTIVE FOR THE PURPOSE OF MEDICAL NECESSITY DETERMINATION

POLICY:

For Advantage MD:
Local Coverage Determinations (LCDs) do not exist at this time. (Accessed December 19, 2017)

Medicare does not have a National Coverage Determination (NCD) for Evaluation and Treatment of Pediatric Feeding Disorders.

I. 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 adolescents with anorexia or bulimia. In particular, this policy specifically defines criteria for referral to a Pediatric Intensive Feeding Program for evaluation and for admission. This is a two stage process and will require separate referrals.
II. When benefits are provided under the member’s contract, JHHC considers an evaluation medically necessary to determine whether a primary pediatric feeding disorder is present for children (age range from 1 – 16 years old) who are not meeting expected growth and physical developmental milestones as demonstrated by their failure to meet expected weight and/or height on growth charts over at least a 2-4 month period.

A. The request for evaluation must include ALL of the following:
   1. Medical evaluation for underlying causes of the growth failure, AND;
   2. Documentation of previous medical and behavioral interventions.

III. When benefits are provided under the member’s contract, JHHC considers admission to an intensive feeding program medically necessary ONLY WHEN ALL of the following criteria are met:

A. The medical evaluation supports the need for the feeding program, AND;
B. Adequate treatment for contributing underlying medical conditions has been documented, AND;
C. A detailed treatment plan is provided, individualized to the child, along with an estimated length of treatment, AND;
D. Elements of behavioral and psychiatric contribution have been addressed. For PPMCO, if the primary cause of the feeding disorder is behavioral, request should be forwarded by the provider to Value Options. The Maryland DHMH (Department of Health and Mental Hygiene) considers Autism Spectrum Disorders to be medical, not behavioral conditions.

IV. When benefits are provided under the member’s contract, JHHC considers intensive inpatient feeding programs an intervention of last resort. To establish medical necessity of an intensive inpatient feeding program ALL of the following must be provided:

A. Documentation of all home, community and outpatient interventions, AND;
B. Documentation of comprehensive psychosocial evaluation demonstrating parental/caregiver compliance with prior interventions, AND;
C. A detailed plan of care that includes early and consistent parental/caregiver participation in treatment, AND;
D. All of the requirements outlined in III above have been met.

V. Unless specific benefits are provided under the member’s contract, JHHC considers intensive treatment for pediatric feeding disorders not medically necessary if growth, physical development and nutrition parameters are within normal limits

BACKGROUND:

Learning to eat is a multi-stage process for children, progressing from the basic suck-swallow of an infant though the stages of increasing consistency and variety of solid foods to an independent eater of a varied and nutritionally adequate diet. It is also a series of social stages from total dependency to an
interactive mealtime. There are many chances for this journey to be interrupted or delayed such as when a child has a medical condition that requires tube feeding for an extended time and then has to learn the basics of swallowing at an age when they would normally be on much more advanced feeds. Children with developmental disabilities may be delayed in learning how to eat. These and any number of issues can lead to feeding problems and feeding disorders.

Feeding Disorders, as opposed to Feeding Problems, are characterized by a child’s inability and/or refusal to eat or drink enough food to maintain normal development and growth. This is generally reflected in the growth chart as weight below 3rd or 5th percentile on more than one occasion or depressed weight for length or a rate of weight gain that causes a decrease in two or more major percentile lines. (Aetna) Occasionally a child will meet normal growth parameters but have such a restricted diet that they are nutritionally at high risk. (Phalen) Severe feeding problems (feeding disorders) are reported in 3-10% of all children and in 26 – 90% of children with physical disabilities, 10 – 49% of children with medical illnesses or prematurity. (Manikam)

Feeding Problems, on the other hand, are characterized by difficulty with feeding issues, while still maintaining normal nutrition, growth and development. Feeding problems are very common in children and range from picky eaters, inconsistent hunger at meal times, food selectivity and inability to stay focused on eating for a sufficient time to consume the meal. They are reported to occur in 25% of all children and up to 80% in developmentally disabled children.

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. Very occasionally, the interaction between parent and child becomes such a problem that intervention is required.

Attempts have been made to classify complex feeding disorders into distinct categories such as structural abnormalities (e.g. cleft palate, tracheostomy), neurologic conditions (e.g. cerebral palsy, muscular dystrophy), behavioral issues (e.g. poor environmental stimulation, dysfunctional feeder-child interaction), cardiorespiratory problems (e.g. bronchopulmonary dysplasia with tachycardia, congenital heart disease), and metabolic dysfunction (e.g. hereditary fructose intolerance, dumping syndrome). In all of these categories there was overlap with other categories and overlap with behavioral issues 92% of the time. (Burklow)

The prevalent nature of behavioral issues, whether primary or secondary, has led to the development of Intensive Feeding Programs which address both the underlying medical issues and the behavioral issues underlying the feeding disorder. One of the tenets of these programs is that the underlying medical conditions must be identified and repaired or treated to the extent possible before the behavioral issues can be addressed effectively. Most intensive feeding programs consist of multi-specialty teams with pediatric gastroenterologists, nutritionists, behavioral therapists, speech and swallowing therapists, and psychologists. There are both outpatient day programs and inpatient programs.
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CODING INFORMATION:

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Note: The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member's specific benefit plan determines coverage and referral requirements. All inpatient admissions require pre-authorization.

PRE-AUTHORIZATION REQUIRED
Compliance with the provision in this policy may be monitored and addressed through post payment data analysis and/or medical review audits

<table>
<thead>
<tr>
<th>Employer Health Programs (EHP) ** See Specific Summary Plan Description (SPD)</th>
<th>Priority Partners (PPMCO) refer to COMAR guidelines and PPMCO SPD then apply policy criteria</th>
<th>US Family Health Plan (USFHP), TRICARE Medical Policy supersedes JHHC Medical Policy. If there is no Policy in TRICARE, apply the Medical Policy Criteria</th>
<th>Advantage MD, LCD and NCD Medical Policy supersedes JHHC Medical Policy. If there is no LCD or NCD, apply the Medical Policy Criteria</th>
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ICD10 CODES ARE FOR INFORMATIONAL PURPOSES ONLY

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>DESCRIPTION</th>
</tr>
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<tbody>
<tr>
<td>F50.82</td>
<td>Avoidant/restrictive food intake disorder</td>
</tr>
<tr>
<td>F50.89</td>
<td>Other specified eating disorder</td>
</tr>
<tr>
<td>F50.9</td>
<td>Eating disorder, unspecified</td>
</tr>
<tr>
<td>F98.29</td>
<td>Other feeding disorders of infancy and early childhood</td>
</tr>
<tr>
<td>J69.0</td>
<td>Pneumonitis due to inhalation of food or vomitus (aspiration pneumonia)</td>
</tr>
<tr>
<td>R62.51</td>
<td>Failure to thrive (child)</td>
</tr>
<tr>
<td>R13.10</td>
<td>Dysphagia (difficulty in swallowing)</td>
</tr>
</tbody>
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REFERENCE STATEMENT:

Analyses of the scientific and clinical references cited below were conducted and utilized by the Johns Hopkins HealthCare LLC (JHHC) Medical Policy Team during the development and implementation of this medical policy. Per NCQA standards, the Medical Policy Team will continue to monitor and review any newly published clinical evidence and adjust the references below accordingly if deemed necessary.
REFERENCES:


