Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

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***Current Policy Effective Date: 5/1/25**
(See policy history boxes for previous effective dates)

Title: Pediatric Feeding Programs

Description/Background

A feeding disorder refers to a condition in which an infant or child refuses to eat or is unable to eat or does not eat enough to gain weight or maintain metabolic needs; thus, compromising the child's growth and development as evidenced by the child's inability to sustain weight and maintain a normal trajectory of growth.

Pediatric inpatient intensive or outpatient intensive feeding programs are multidisciplinary programs that have been proposed to provide treatment for children with severe impairment of oral intake that has severely affected that child's ability to grow and develop. Medical and developmental conditions including abdominal malformations, prematurity, autism spectrum disorder, or other behavioral disorders, developmental delays or disabilities, Downs syndrome, gastroesophageal reflux and oral aversions may cause an array of feeding challenges. Dysfunctional eating habits and inappropriate behavior during mealtimes can be a result of dysphagia (difficulty swallowing), food aversion, consistent food refusal, food intolerances, an inability to self-feed, restrictive eating patterns, difficulty transitioning to age-appropriate textures, recurrent vomiting, choking, gagging and food allergies.

The pediatric feeding programs multidisciplinary team incorporates a supportive and comprehensive approach that addresses a child's medical and developmental needs, behavioral issues, and oral-motor challenges with the goal of the child obtaining healthy habits during mealtimes and obtaining appropriate growth trajectories. The comprehensive approach engages with families to help the child achieve developmentally appropriate nutritional habits. An essential part of sustaining learned meal-time habits and encouraged continuance of age-appropriate healthy habits, is the analysis and education of parenting techniques and behaviors regarding food.

Length of engagement is typically within a 6-12 week timeframe. These programs combine medical, behavioral health and rehabilitative techniques and provide these services on an intensive basis. The proposed treatment is geared towards establishing proper feeding and nutritional habits so that additional health complications may be avoided.

The professional staff of a pediatric feeding program may include but are not limited to the following specialists:

- Neurodevelopmental pediatrician
- Pediatric nurse practitioner
- Pediatric behavioral psychologist
- Medical social worker specializing in pediatrics
- Occupational/physical therapist specializing in pediatrics
- Speech and language pathologist specializing in pediatrics
- Registered dietitian, certified, specializing in pediatrics

The feeding program may be intensive outpatient day-patient or intensive inpatient. Candidates may be categorized for these programs as follows:

- Children with mild to moderate feeding difficulties and who are medically and nutritionally stable may be candidates for traditional outpatient services.
- Patients with moderate to severe feeding difficulties who are medically and nutritionally stable may be candidates for intensive day-patient services.
- Patients who are refractory to outpatient or day-patient intensive services or are at risk for medical complications secondary to inadequate fluid or caloric intake may be candidates for intensive inpatient services.

Regulatory Status

N/A

Medical Policy Statement

The safety and effectiveness of pediatric feeding programs have been established. The multidisciplinary, integrated programs may be considered a useful therapeutic option when indicated.

Inclusionary and Exclusionary Guidelines

Inclusions:

Intensive outpatient day feeding programs may be considered established in children[a] when ALL the following criteria have been met:

- Referral by qualified medical professional experienced in the care of children, after a thorough medical and nutritional evaluation has been completed to identify potentially treatable underlying conditions (endocrine disorders, thyroid disease, etc.)

- A pattern of significant malnutrition and/or failure-to-thrive exists that is felt to be related to inadequate dietary intake resulting from an abnormal relationship to food (aversion, swallowing dysregulation, etc.)
    - Age-appropriate growth charts and/or BMI Tables may be used to document growth and weight gain[b].
- A 3-4 month trial of at least one traditional outpatient approach[c] to improve dietary intake and growth has failed.

Intensive inpatient admission for pediatric intensive feeding program services may be considered established when facility-based care is required, and ALL of the following criteria have been met:

- All of the above (Intensive outpatient day) criteria have been met
- Member is deemed medically unstable as evidence by one or more of the following:
    - Bradycardia
    - Congestive heart failure
    - Dehydration (documented clinically and on labs)
    - Electrolyte abnormalities
    - Hypotension
    - Hypothermia
    - Other clinical circumstances where cardiac, pulmonary, hepatic, metabolic or renal status are at risk in the judgment of the attending physician

[a] *Children are defined as less than 18 years of age*

[b] *Special growth charts for selected genetic syndromes should be used when indicated (e.g., Down's syndrome, Turner syndrome, etc.)*

[c] *Outpatient traditional approaches may include but are not limited to: Parent/caregiver evaluation to determine if parenting dynamics may be impacting ability to eat and/or gain weight; Gastrointestinal evaluation to rule out primary GI diagnosis or intestinal mechanical issues; Calorie counts; Home based feeding strategies; Behavioral evaluation to ascertain impacts on feeding; Physical therapy and/or occupational evaluation to help assess developmental challenges that may impact feeding.*

Exclusions:

- Children who have mild to moderate feeding difficulties who continue to meet normal growth and developmental milestones
- Services provided by professionals within a Pediatric Feeding Program should not be duplicated concurrently by providers outside of the Feeding Program. Such services are duplicative and "Not a Covered Benefit"
- Maintenance programs

Policy Guidelines

- Movement within the program (outpatient or inpatient therapy) is based on the candidates' clinical needs and response to therapeutic interventions.
- Per diem code (S0317) should be submitted to represent services provided as part of a Pediatric Feeding Program, but it should not be billed with other related incremental codes

on the same date of service or during a Pediatric Feeding Program treatment cycle (unbundling).
- Parents/Guardians should check benefit status to determine the need for prior authorization.
- Evaluation and Management, Behavioral, Rehabilitative, and other services that may be required after the individual is no longer receiving Pediatric Feeding Program intensive services, should be billed using appropriate procedure or billing codes. These subsequent services should be within the individuals routine scope of benefit coverage and do not represent an extension of the child's coverage of Pediatric Feeding Program services.

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure.)*

Established codes:

S0317

Other codes (investigational, not medically necessary, etc.):

N/A

Note: Code(s) may not be covered by all contracts or certificates. Please consult customer or provider inquiry resources at BCBSM or BCN to verify coverage.

Rationale

According to the University of Michigan (2018) severe feeding disorders affect up to 10% of children without medical or developmental issues, 70-90% of children born prematurely or with chronic medical issues, and up to 90% of children with autism. These children face compounded risk: a lack of adequate nutrition can negatively impact growth, brain development, and heart health, as well as mental health and social development. Interdisciplinary Pediatric Feeding Programs offer an intensive outpatient all-day model of care which includes 3-4 meals per day, intensive parent-training as it relates to feeding, nutritional and medical monitoring, and psychosocial support. The typical amount of time spent in an intensive outpatient day treatment program is 6-12 weeks (Monday-Friday).

Pediatric feeding disorders are often seen in the first 3 years of life. Although feeding disorders have the potential to be multifaceted, children who have experienced significant medical and developmental challenges are at greatest risk. A non-exhaustive list of feeding problems includes, but may not be limited to, inappropriate mealtime behaviors, lack of self-feeding, food selectivity, failure to advance texture from puree to table food textures, food refusal, oral-motor immaturity or dysfunction, aspiration or swallowing problems, frequent vomiting.

The daily norm of 3 meals a day may not fit in with a child's body signals and their eating tendencies. Children are predisposed to listen to their bodies and eat only when they are hungry. Thus "feeding problems" are commonly perceived in healthy infants and young children when they choose not to participate at scheduled mealtimes. Although this behavior can and does cause stress in the parents/caregivers, these normal behaviors are usually

short-lived. When parents/caregivers seek help, treatment may include parent training, nutrition education, interaction coaching and suggestions for presentation and preparation of food which can easily be addressed by pediatricians and pediatric psychologists.

Many reversible feeding disorders stem from a medical issue which can easily be resolved, such as gastroesophageal reflux disease, via an individual treatment component versus a group/program approach. Children with feeding difficulties may inadvertently develop negative associations with oral intake, promoting the potential for continued avoidance behaviors after the medical issue has been resolved. Conditioned food aversion may result when food is paired with an unpleasant consequence such as pain, nausea, or fatigue.

When a child's mealtime behavior becomes maladaptive in response to environmental or psychosocial factors, it is often approached with psychological and behavioral interventions. A clinician's observation of mealtime behavior (between the parent and the child) paired with the parents report of mealtime behavior can help to provide a better understanding of the relationships between parent behavior, child behavior, and nutrition; thus, helping to identify any deficits.

Seiverling et al (2019) examined changes in child mealtime behavior, diet variety, and family mealtime environment after intensive interdisciplinary behavioral treatment for 52 children referred to a day treatment feeding program. Children fell into 3 developmental status groups including autism spectrum disorder (*n*=16), other special needs (*n*=19), and no special needs (*n*=17), with some having no known medical problems (*n*=22) and some having gastrointestinal, cardiopulmonary, and/or endocrine-metabolic problems (*n*=28). At pre-intervention and post-intervention, caregivers completed the "About Your Child's Eating Scale, the Brief Assessment of Mealtime Behavior in Children", and a food preference inventory of 70 common foods (20 fruits, 23 vegetables, 12 proteins, 8 grains, 7 dairy). Mixed-factor 2×3 analysis of variance (ANOVAs) compared each of the 11 feeding outcomes across the 2 study phases (pre-, post-intervention) for the 3 developmental status groups. All feeding outcomes except fruit acceptance showed significant improvements from pre- to post-intervention, with no main effects for developmental status, and no interaction effects. Additionally, mixed-factor 2×2 ANOVAs compared each of the 11 feeding outcomes across the 2 study phases (pre-, post-intervention) for children with and without medical problems. All feeding outcomes except fruit acceptance showed significant improvements from pre- to post-intervention, with no main effects for medical status, and no interaction effects. Present results suggest that intensive interdisciplinary behavioral treatment (is effective for improving a number of children's feeding problems, regardless of their developmental or medical status.

McComish et al (2016) described pediatric feeding problems as complex problems with multiple interacting systems which contribute to the problem. Feeding problems are known to have an impact on the child and family, and can influence growth, health, and quality of life. McComish et al concluded that children who need assessment and individualized treatment for complex feeding problems are best served by an interdisciplinary collaborative treatment team. The medical, motor, and behavioral approach to treating pediatric feeding problems is an approach to treatment that requires a well-functioning interdisciplinary team, including nurses, physicians, registered dietitians, and feeding therapists (speech- language pathologists, occupational and physical therapists).

Greer et al (2007) investigated the impact of an intensive interdisciplinary feeding program on caregiver stress and child outcomes of children with feeding disorders (tube dependent, liquid dependent, or food selective groups). Outcomes for caregiver stress levels, child mealtime behaviors, weight, and calories were examined at admission and discharge for 121 children. Authors reported that caregiver stress, child mealtime behaviors, weight, and caloric intake improved significantly following treatment in the intensive feeding program, regardless of category placement. The successful treatment of a feeding disorder often relies upon establishing a new and positive learning history with eating between the child and caregiver.

Kim et al (2021) evaluated the effectiveness of a multidisciplinary inpatient treatment model for feeding disorders by analyzing long-term nutritional and health outcomes 12 months following discharge. Fifty patients completed the study. Average caloric intake by mouth as a percentage of goal for gastrostomy tube (GT)-dependent patients (n=31) increased from pre-admit, week 1, and week 2 of the inpatient program (30%, 70%, and 84%, respectively), and was sustained from week 3 to 12-month follow-up (85% and 86%, respectively). Eighty-one percent were discharged without GT support and 65% remained off GT support at 12 months. Oral supplement dependence for non-GT patients (n=19) decreased from pre-admit, discharge, and 12-month follow-up (51%, 31%, and 19% of caloric intake, respectively). BMI z-scores improved during and after treatment. The present study demonstrated an effective approach for treatment of pediatric feeding disorders, including decreased reliance on oral supplementation and GT dependence.

The North American Society for Pediatric Gastroenterology, Hepatology and Nutrition recommends a multidisciplinary approach to monitoring the nutritional status of neurologically impaired children. A team of pediatric specialists, including physicians, nurses, dietitians, occupational and speech therapists, psychologists, and social workers can provide early, efficient nutritional intervention to ensure normal growth, optimal functional status, and quality of life.

Summary of Evidence
Appetite manipulation and behavioral therapy in an intensive outpatient day program have proven to be efficacious; thus, reducing the need for more intense interventions. An outpatient intensive day program typically consists of 5, 8-hour days per week. During this time, the child and the caregiver receive support with 3 to 4 feeding exercises and education is provided as needed. Other therapies may be provided as needed between feeding times. In most situations, intensive outpatient therapy will meet the child’s and the caregivers needs. Most issues can be resolved by addressing any existing medical issues, social problems, environmental factors and/or developmental requirements/gaps.

Intensive inpatient programs are generally recommended for children who require around-the-clock medical care/supervision due to medical issues that were cause from or affected by severe feeding difficulties (i.e., bradycardia, congestive heart failure, dehydration, electrolyte abnormalities, hypotension, hypothermia, or other clinical circumstances where cardiac, pulmonary, hepatic, metabolic or renal status are at risk per the judgement of the attending physician). The child’s overall health and development, and the parent-child relationship are affected by a severe feeding disorder. Significant emotional distress in the parent/caregiver affects the well-being of both the child and the parent/caregiver.

Pediatric feeding disorders can be single- or multifaceted. Multidisciplinary interventions suggest positive effects in the preliminary phase of evidence and can be provided on an intensive inpatient basis or with daily intensive outpatient interventions.

Supplemental Information

POSITION STATEMENTS
The North American Society for Pediatric Gastroenterology, Hepatology and Nutrition (2006) support, “Early involvement by a multidisciplinary team of physicians, nurses, dieticians, 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 disabled children for nutritional problems are warranted because of the increased risk of nutrition-related morbidity and mortality” for neurologically impaired children.

Government Regulations
National/Local:
There is no national or local coverage determination regarding pediatric feeding programs.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

N/A

References

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The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through January 3, 2025, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
9/1/18	—	—	Joint policy established
9/1/19	—	—	Tabled
5/1/20	5/1/20		Routine maintenance
5/1/21	2/16/21		• Pediatric age clarified (< 18) • Examples of outpt approaches provided – not intended to be all inclusive
5/1/22	2/15/22		• Routine maintenance
5/1/23	2/21/23		• Routine maintenance (slp) • Vendor Managed: N/A
5/1/24	2/20/24		• Routine maintenance (slp) • Vendor managed: N/A
5/1/25	2/18/25		• Routine maintenance (slp) • Vendor managed: N/A

Next Review Date: 1st Qtr, 2026

Pre-Consolidation Medical Policy History

Original Policy Date	Comments
BCN: 4/15/09	Revised: 1/18/17
BCBSM: N/A	Revised: N/A

BLUE CARE NETWORK BENEFIT COVERAGE POLICY: PEDIATRIC FEEDING PROGRAMS

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered; criteria apply.
BCNA (Medicare Advantage)	Refer to the Medicare information under the Government Regulations section of this policy.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the individual member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.
- *Duplicate (back-up) equipment is not a covered benefit.*