



CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all health benefit plans administered by CIGNA Companies including plans formerly administered by Great-West Healthcare, which is now a part of CIGNA.

Subject **Speech Therapy for Swallowing and Feeding Disorders**

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Coverage Policy

Swallowing/feeding therapy is considered a form of speech therapy. Coverage for outpatient speech therapy and speech therapy provided in the home is subject to the terms, conditions and limitations of the Short-Term Rehabilitative Therapy benefit as described in the applicable benefit plan's schedule of copayments.

Outpatient swallowing/feeding therapy is the most medically appropriate setting for these services unless the individual independently meets coverage criteria for a different level of care.

Many benefit plans have exclusion language that impacts coverage of speech therapy, including any or all of the following:

- **A maximum allowable speech therapy benefit for duration of treatment or number of visits. When the maximum allowable benefit is exhausted, coverage will no longer be provided even if the medical necessity criteria described below are met.**
- **Specific coverage exclusions for behavioral training/treatment or services that are considered educational and/or training in nature.**
- **Specific coverage exclusions for maintenance or preventive care consisting of routine, long-term, or non-medically necessary care provided to prevent recurrences or to maintain the member's current status.**

- **Under many benefit plans formerly administered by Great-West Healthcare, speech therapy for swallowing and feeding disorders is only covered following acute injuries, diseases or conditions when the therapy services are expected to result in significant clinical improvement within two months.**

If coverage for this service is available, the following conditions of coverage apply.

CIGNA covers a swallowing/feeding evaluation as medically necessary for the assessment of a swallowing/feeding disorder.

CIGNA covers swallowing/feeding therapy as medically necessary for individuals with swallowing and children with a feeding disorder when ALL of the following criteria are met:

- The swallowing or feeding disorder is the result of an underlying medical condition.
- 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.
- The therapy plan includes specific tests and measures that will be used to document significant progress.
- Meaningful improvement is expected from the therapy.
- The treatment includes a transition from one-to-one supervision to an individual or caregiver provided maintenance level on discharge.

CIGNA does not cover swallowing/feeding therapy in ANY of the following situations, as it is excluded from many benefit plans and considered not medically necessary when used for these purposes:

- treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- treatment intended to improve or maintain general physical condition
- long-term rehabilitative services when significant therapeutic improvement is not expected
- swallowing/feeding therapy that duplicates services already being provided as part of an approved therapy program through another therapy discipline (e.g., occupational therapy)

CIGNA does not cover swallowing/feeding therapy for food aversions because it is considered behavioral training and not medically necessary.

CIGNA does not cover electrical stimulation for swallowing/feeding disorders because it is considered experimental, investigational or unproven.

General Background

Difficulty with swallowing is also referred to as dysphagia or deglutition disorder. Pain in swallowing may accompany dysphagia, and this is referred to as odynophagia. An inability to swallow is known as aphagia. Swallowing is a complex function that involves the mouth, pharynx, larynx and esophagus. The phases of swallowing include: oral preparation and oral propulsive, pharyngeal and esophageal (Palmer, 2000). Dysphagia is classified according to which phase of swallowing is affected (Palmer, 2000).

In infants, the first phase also includes the sucking reflex. The sucking reflex initiates swallowing in the infant by stimulation of the lips and deeper parts of the oral cavity (Derkay, et al., 1998). Oral skills such as sucking or chewing solids are learned only at certain ages. Infants who do not learn these skills at the specific times in their development may have a difficult time mastering them at a later time, leading to feeding problems.

Infants and children with cleft lip and/or palate can usually feed by mouth with some adjustments. These patients may have difficulties maintaining sucking pressure; however, the swallowing mechanisms are usually normal. If milk or formula can reach the oropharynx, then the natural swallowing reflexes can move it to the esophagus (American Cleft Palate-Craniofacial Association [ACPA], 2004). Feeding times may be lengthened

considerably due to difficulties with maintaining the sucking pressure. There may also be breathing problems present during the feeding.

The most common signs and symptoms of dysphagia are coughing or choking while eating, or the sensation of food sticking in the throat or chest. Signs and symptoms of dysphagia may also include (Palmer, 2000): difficulty initiating swallowing, drooling, unexplained weight loss, change in dietary habits, recurrent pneumonia, change in voice or speech, nasal regurgitation, and dehydration. Infants may exhibit a feeding disorder with signs and symptoms that include: refusal to eat or drink, failure to gain weight, aversions to specific food types or textures, recurrent pneumonias and chronic lung disease. Consequences of dysphagia and feeding disorders may be severe and may include: dehydration, malnutrition, aspiration, choking, pneumonia, and death.

Evaluation of swallowing and feeding disorders first includes performing a history and physical exam. During the physical examination, the patient should be observed during the act of swallowing. A clinical dysphagia evaluation is usually completed by a speech-language pathologist. The examination will include: assessment of posture, positioning, patient motivation, oral structure and function, efficiency of oral intake and clinical signs of safety. A variety of positions, feeding techniques and adaptive utensils may be used during the examination. In infants, the oral-motor assessment includes evaluation of reflexive rooting and non-nutritive sucking (Darrow and Harley, 1998). Two scales that may be used in evaluation of infants include the Neonatal Oral-Motor Assessment Scale (NOMAS) and the Multidisciplinary Feeding Profile (MFP). Infants and children may require additional assessments, as growth, development and changes in medical condition may affect the swallowing process.

The videofluorographic swallowing study (VFSS), also referred to as modified barium swallow, is the gold standard for evaluating the mechanism of swallowing (Palmer, 2000). This test is usually performed jointly by a physician and a speech-language pathologist. The study will demonstrate anatomic structures, the motions of these structures, and passage of the food through the oral cavity, pharynx and esophagus (Palmer, 2000). Additional diagnostic testing that may be employed includes (Palmer, 2000; Darrow and Harley, 1998): esophagoscopy; esophageal manometry and pH probe studies; electromyography; fibroptic endoscopic examination of swallowing (FEES) and, ultrasound imaging.

Swallowing and feeding disorders in children and infants are complex and may have multiple causes. Underlying medical conditions that may cause dysphagia may include, but are not limited to (Palmer, 2000; Rudolph, et al., 2002):

- neurological disorders (e.g., cerebral palsy)
- disorders affecting suck-swallow-breathing coordination (e.g., bronchopulmonary dysplasia)
- structural lesions (e.g., neoplasm)
- connective tissue disease (e.g., muscular dystrophy)
- iatrogenic causes (e.g., surgical resection, medications)
- anatomic or congenital abnormalities (e.g., cleft lip and/or palate)

Therapy for Swallowing and Feeding Disorders

When possible, initial treatment of swallowing and feeding disorders is aimed at treating the underlying cause. Depending on the etiology, surgery or pharmacologic therapy may be used. However, the causes of many of the disorders resulting in dysphagia may not be amenable to pharmacologic therapy or surgery. In these cases, a referral to a speech-language pathologist for evaluation is appropriate.

The goals of therapy include reducing aspiration, improving the ability to eat and swallow, and optimizing the nutritional status (Palmer, 2000). The choice of therapies is directed by the videofluoroscopic findings and the individual's ability to comprehend and cooperate with the various strategies (Cook, et al., 1999).

The specific strategy that is utilized will depend on the dysfunction that is present. Swallowing therapy strategies may include:

- Dietary modifications: This technique may be used if the patient aspirates on only certain substances while swallowing.
- Swallow therapies: These therapies include the following:

- Compensatory techniques: This technique teaches the patient postural maneuvers to compensate for swallowing difficulty.
- Indirect swallow therapy: This technique teaches the patient exercises to strengthen impaired or weakened muscles.
- Direct swallow therapy: This technique teaches the patient exercises to perform during the swallowing process.

When a patient is unable to achieve adequate alimentation and hydration by mouth, enteral feedings through a nasogastric tube (NG) or a percutaneous endoscopic gastrostomy (PEG) may be necessary. The presence of a feeding tube is not a contraindication of therapy. Removal of the feeding tube may be a goal of therapy.

Swallowing/feeding therapy is generally provided by a speech-language pathologist. At times an occupational therapist may also provide some of the treatment. There should be a documented plan of care that includes specific measures that will be used to assess progress and objective long- and short-term goals. Each treatment provided and patient response should be documented in the progress notes. 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 patient's condition.

Swallowing/Feeding Therapy for Infants and Children

Strategies that are used with adults are often difficult to teach to children. Therapies directed toward strengthening of swallowing musculature may be useful for children with a swallowing or feeding disorder due to an underlying medical condition (Rudolph, 2002). Feeding therapy for infants and children may include the following strategies (Arvedson, 1998):

- Position and posture changes: Trunk and head control are closely related to development of oral-motor skills. In particular, children with cerebral palsy and accompanying motor deficits frequently have poor head control and poor trunk stability. Position changes need to be monitored closely for changes over time.
- Changes in food and liquid attributes: These attributes may include, but are not limited to: volume, consistency, temperature and taste.
- Oral-motor and swallow therapies: These procedures are focused on developmental stages with goals to increase the range of textures children can handle in their diets. Oral-motor treatment can include direct exercises of the oral mechanism. Oral-motor treatment may also benefit non-oral feeders. Development of swallowing skills may have a positive effect on the process of swallowing saliva. The therapist can guide and direct caregivers to carry out an oral stimulation.
- Pacing of feedings: Pacing is a technique that regulates the time interval between bites or swallows. This may minimize the risk of aspiration. Some children may need a longer time to swallow.
- Changing of utensils: The food bolus size can be controlled through spoons of different shapes and sizes. Occupational therapists may recommend adaptive equipment and utensils.

Food aversion may be present without an underlying medical condition. Food aversion may also include food selectivity. This may be demonstrated by consumption of a limited variety of food items and the rejection of other items. If needed, behavioral therapy may be used to overcome this condition. Therapy provided for children with these conditions is considered behavioral and training in nature.

Specialized feeding techniques that are used for feeding infants with cleft lip and/or palate have been developed to overcome the lack of negative pressure developed during sucking; these strategies may include (ACPA, 2004):

- cross-cutting fissured nipples
- squeezing a soft bottle to help with the flow of milk
- pumping breast to deliver breast milk via bottle

Literature Review: There are limited published clinical trials that assess the specific treatments for dysphagia and the effect of the treatments. Foley et al. (2008) reported on a systematic review of randomized controlled trials that evaluated dysphagia treatment post-stroke. Fifteen studies were included that covered a broad range of treatments, including: texture-modified diets, general dysphagia therapy programs, non-oral (e.g., enteral)

feeding, medication and physical and olfactory stimulation. There was heterogeneity of the treatments evaluated and the outcomes assessed which precluded the use of pooled analyses. The review found that general swallowing treatment programs are associated with a reduced risk of pneumonia in the acute stage of stroke. Swallowing therapies and interventions in current practice appear to be based on clinical experience approaches that are physiologically based. The authors concluded that there is a need for high-quality research to identify effective dysphagia treatments post-stroke.

A Cochrane review (Deane, et al., 2001) was conducted to compare the efficacy and effectiveness of non-pharmacological swallowing therapies for dysphagia in patients with Parkinson's disease. The researchers noted that no controlled trials, randomized or otherwise, were found that examined the efficacy of non-pharmacological swallowing therapy for treatment of dysphagia in patients with Parkinson's disease. They did note that this lack of evidence does not mean lack of effect. The review concluded that there is currently no evidence to support or refute this therapy for patients with Parkinson's disease.

Bath et al. (2000) conducted a Cochrane review to assess the effect of different management strategies for dysphagic stroke patients, including whether therapy improves swallowing and clinical outcome. Six studies were identified that assessed feeding and swallowing treatment strategies in stroke patients, with two studies that assessed the effect of swallowing therapy. These two trials indicated that formal swallowing therapy was associated with a nonsignificant reduction in end-of-trial dysphagia as compared to standard of care. It was noted by the authors that too few studies have been performed involving too few patients. The review concluded that further research is required to assess how and when patients are fed, and the effect of swallowing or drug therapy on dysphagia.

Professional Societies/Organizations

The American Gastroenterological Association (AGA) published a technical review on management of oropharyngeal dysphagia (Cook, et al., 1999). They note that, "the literature provides reasonable evidence of the plausibility of swallowing therapy but minimal evidence of efficacy. Nonetheless, although no hard evidence supports its efficacy, the available data are inconclusive and swallowing therapy has not been proven ineffective." The AGA review recommends that swallowing therapy should be used based on the current weight of opinion, combined with convincing demonstration of biological plausibility for specific techniques and the consistency of low-grade evidence. The review also notes that large-scale randomized, controlled trials are needed to clarify the current recommendations.

The American College of Chest Physicians (ACCP) published evidenced-based clinical practice guidelines regarding cough and aspiration of food and liquids due to oral-pharyngeal dysphagia (Smith Hammond, et al., 2006). The guidelines note that the treatment of dysphagic patients by a multidisciplinary team, including early evaluation by a speech-language pathologist, is associated with improved outcomes. The ACCP also notes that, "Effective clinical interventions such as the use of compensatory swallowing strategies and the alteration of food consistencies can be based on the results of instrumental swallowing studies."

Electrical Stimulation for Dysphagia

Electrical stimulation has been proposed as a treatment for dysphagia. This may involve either direct electrical stimulation of the oral structure, or transcutaneous stimulation of the throat musculature. It appears the goal of the therapy is to stimulate and re-educate the neuromuscular pathways involved in swallowing.

U.S. Food and Drug Administration (FDA): An electrical stimulation device, VitalStim® (Empi, Inc., St. Paul, MN) was developed for the treatment of dysphagia. It was granted 510(k) premarket approval by the U.S. Food and Drug Administration (FDA) in 2001. The VitalStim Experia® clinical device (Empi, Inc., St. Paul, MN) received 510(k) approval in 2007. These are classified as Class II devices by the FDA with the listed indication for use: muscle re-education by application of external stimulation to the muscles necessary for pharyngeal contraction.

Literature Review—Electrical Stimulation for Dysphagia: A systematic review the literature examining the effects of neuromuscular electrical stimulation (NMES) on swallowing and neural activation was conducted by Clark, et al. (2009). The review included 14 trials. Most of the studies (10/14) were considered exploratory research (non-experimental design conducted on non-disordered populations or used NMES as a condition to examine swallowing abilities instead of an intervention). Many of the studies were noted to have significant methodological limitations. The authors concluded that the systematic review "reveals that surface NMES to the

neck has been most extensively studied with promising findings, yet high-quality controlled trials are needed to provide evidence of efficacy. Surface NMES to the palate, faucial pillars, and pharynx has been explored in Phase I research, but no evidence of efficacy is currently available. Intramuscular NMES has been investigated in a single Phase I exploratory study.”

In a randomized, controlled trial, Permsirivanich et al. (2009) compared NMES (n=12) to rehabilitation swallowing therapy (RST) (n=11) in stroke patients with persistent pharyngeal dysphagia. Patients were treated for four weeks or until they reached functional oral intake scale (FOIS) level 7 (i.e., total oral diet with no restrictions). In the NMES group, 58.33% of the patients improved four FOIS levels and 33.34% improved 2–3 levels compared to 45.46% who improved three levels and 36.36% who improved two levels in the RST group. A statistically significant difference was seen in the average changes in the FOIS scores for the RST group (2.46 ± 1.04) vs. the NEMS group (3.17 ± 1.27) ($p < 0.001$). Further studies with long-term outcomes and larger patient populations are indicated to validate the results of this study and to establish the “the effects of NMES on specific biomechanical aspects of pharyngeal swallowing, as well as the best location for electrode adhesion, effects of varying frequencies and amplitude of electrical stimulation on swallowing physiology, duration of each session, and total number of sessions”.

Lim et al. (2009) reported on a randomized, controlled trial that assessed the effectiveness of neuromuscular electrical stimulation in 36 patients with dysphagia caused by stroke. The control group was given thermal-tactile stimulation treatment only, while in the experimental group neuromuscular electrical stimulation and thermal-tactile stimulation treatments were applied simultaneously. Swallowing function was assessed before and 4 weeks after treatment, and evaluated via the swallow function scoring system, penetration-aspiration scale, and pharyngeal transit time. In addition, the discomfort score during the treatments and the satisfaction score 4 weeks after the treatments were measured. The study was completed by 28 patients (16 in experimental group; 12 in control group). Improvement was noted in both groups, but there was greater improvement seen in experimental group in the swallow function scoring system, penetration-aspiration scale and pharyngeal transit time than the control group. The discomfort score did not show statistically significant differences in either group, but the satisfactory score was higher in the experimental group. Limitations of this study include the small size and short follow-up time period.

Ryu et al. (2008) reported on a prospective, double-blinded, randomized case control study of 14 patients. The patients were randomized to 30 min of NMES and 30 min of traditional swallowing training for 5 days per week for 2 weeks (experimental group), and 12 patients were randomized to sham stimulation plus traditional swallowing training (control group). Assessment with the clinical dysphagia scale (CDS), the functional dysphagia scale (FDS), the American speech-language-hearing association national outcome measurement system (ASHA NOMS) and the M.D. Anderson dysphagia inventory (MADI). The average changes of FDS score were 11.4 ± 8.1 for the experimental group and 3.3 ± 14.0 for the control group ($p = 0.039$). There were some changes with the CDS, ASHA NOMS and MADI, but they were not significant ($p > 0.05$). Limitations of the study includes small number of patients, heterogeneity, use of sham stimulation and the follow-up rate was 67% in experimental group and 48% in control group which may have affected the result.

Bulow et al. (2008) conducted randomized trial to evaluate and compare the outcome of NMES as compared to traditional swallowing therapy (TT) in 25 stroke patients. The patients were randomized to NMES (n=12) and to TT (n=13). Pre- and post-trial measures included videoradiographic swallowing evaluation, nutritional status, oral motor function test, and a visual analog scale (VAS) for self-evaluation of complaints. Fifteen therapy sessions were rendered to all patients. There were statistically significant positive therapy effects for both groups combined but there were no statistically significant difference in therapy effect between the groups. The correlation between the different measurements was found to be low. The patient’s subjective experience of improvement did not correlate with objective videography—the authors note that a false-positive perception of improvement may lead to serious swallowing complications, such as choking. At least of two of the patients in the study were treated for severe aspiration pneumonia a couple of months after the study (randomized for NMES). It was proposed that since these patients had positive post-treatment VAS score, felt they had recovered from swallowing difficulties and did not follow the diet modification recommendation.

A meta-analysis was conducted to evaluate the effect of transcutaneous NMES on swallowing rehabilitation (Carnaby-Mann, et al., 2007). The review included 7 studies with a total of 255 patients with dysphagia due to multiple etiologies. Therapeutic outcome was evaluated using various methods that included swallowing scale, weight gain, functional eating, residue on a swallowing x-ray study, or laryngeal elevation. The treatment was

provided over a variable period of one to 24 weeks, with a number of total treatment sessions varying across the studies. The NMES electrode placement was not detailed in two of the seven studies. A significant summary effect size was identified for the application of NMES for swallowing ($p < .001$). The heterogeneity was significant for the combined trials ($p < .10$). When two outlier trials were removed, the heterogeneity was no longer significant ($p < .08$). The best-evidence synthesis demonstrated indicative findings in favor of NMES for swallowing. The authors concluded that, "This preliminary meta-analysis revealed a small but significant summary effect size for transcutaneous NMES for swallowing." However, the authors note that, "because of the small number of studies and low methodological grading for these studies, caution should be taken in interpreting this finding." In addition, they note that, "further independent trials with rigorously controlled designs and intent-to-treat analyses are needed to establish whether NMES for swallowing has greater efficacy than traditional swallowing treatments alone."

Ludlow et al. (2007) conducted a study to test two hypotheses regarding the effect of using surface electrical stimulation in 11 patients with chronic pharyngeal dysphagia. Electrodes were placed on the skin overlying the submandibular and laryngeal regions. Video fluoroscopy was used to measure hyoid movements in the superior-inferior and anterior-posterior dimensions and the subglottic air column positions while the stimulation was on and off. The frequency of aspiration, penetration, pooling and esophageal entry was measured by speech pathologists blinded to the condition. The results noted only significant ($p = 0.0175$) hyoid depression occurred during stimulation at rest; aspiration and pooling were significantly reduced only with low sensory threshold levels of stimulation ($p = 0.025$) and not during the maximum levels of electrical stimulation. The authors note that the patients who had reduced aspiration and penetration during swallowing with stimulation had greater hyoid depression during stimulation and propose that stimulation may have acted to resist patients' hyoid elevation during swallowing. The authors noted that before this is used in therapy, "improved understanding of its immediate effects should be gained in the presence of specific types of swallowing difficulties before it is applied widely to a variety of patients regardless of their risk of aspiration with hyoid lowering."

Kiger et al. (2006) conducted a study to compare the outcomes using VitalStim therapy to outcomes using traditional swallowing therapy for deglutition disorders. The study included 22 patients who were divided into an experimental group who received treatment with VitalStim and a control group who received traditional swallowing therapy. Outcomes were analyzed for changes in oral and pharyngeal phase dysphagia severity, dietary consistency restrictions and progression from nonoral to oral intake. The results of the study indicated that the control group made more improvement in the oral phase than the experimental group; however, these results were not statistically significant ($p \geq 2.307$). Regarding diet consistency advancement, it was noted that subjects in both groups were identified as having diet consistency advancement, no change or a more restrictive diet/liquid consistency. The results for this measure were not statistically significant ($p \geq 1.0526$). In relation to the measure of improvement, to evaluate those patients who were initially determined to have no oral intake but improved to oral intake following intervention, the results were statistically not significant ($p \geq 0.0314$).

A prospective study of 23 patients was conducted to test the hypothesis that synchronous contraction of the thyrohyoid muscle by electrical stimulation during swallowing would improve dysphagia (Leelamanit, et al., 2002). Treatment was provided daily for four hours until criteria for improved swallow were fulfilled or other intervention was deemed necessary. Follow-up was performed monthly. It was noted that of the 23 patients, 20 showed improvement. Six patients who had achieved improved swallow criteria relapsed at 2–9 months. The authors note that this is a preliminary study of this treatment and that long-term follow-up is needed in a larger group of patients with reduced laryngeal elevation.

A nonconcurrent cohort study for the purpose of evaluating the efficacy of electrical stimulation in treating patients with dysphagia and aspiration was reported by Blumenfeld et al. 2006. The charts of 40 patients undergoing electrical stimulation and 40 patients who underwent traditional dysphagia therapy were retrospectively evaluated. A swallow severity scale was used to compare pre- and post-therapy treatment success. The swallow severity scale improved from 0.50 to 1.48 in the dysphagia therapy group ($P < 0.05$) and from 0.28 to 3.23 in the electrical stimulation group ($p < 0.001$). After adjustments were made for confounding factors, the study noted that patients receiving electrical stimulation appeared to do better with regard to improvement in their swallow function than those receiving dysphagia therapy ($p = 0.003$). The authors concluded that, "the results of this nonconcurrent cohort study suggest that dysphagia therapy with transcutaneous electrical stimulation is superior to traditional dysphagia therapy alone in individuals in a long-term acute care

facility.” The study acknowledged that, “these results must be confirmed with a prospective, randomized, placebo-controlled, clinical trial in individuals of varying disease severity and rehabilitation potential.”

Freed et al. (2001) conducted a nonrandomized, controlled study comparing electrical stimulation to tactile thermal stimulation. One hundred and ten stroke patients with swallowing disorder were enrolled, with 99 completing treatment. Electrical stimulation was applied through transcutaneous electrodes placed on the neck. It was noted that the electrical stimulation group was treated for a longer period of time than the tactile thermal stimulation group. For both groups, follow-up was based on medical records (for readmission) or consultation with the patient, family, physician or nursing home therapist for up to three years. It was noted that there was not a systematic method of data collection or analysis and that follow-up was not performed with all patients. Both sets of patients showed improvement in swallow scores. In a critical appraisal of this study (Coyle, 2002) it is noted that “perhaps a more valid comparison might have been comparing ES (electrical stimulation) to conventional therapy, consisting of combinations of procedures routinely used in clinics for similar patients.” It is also noted by Coyle that “although electrical stimulation may be determined at some point to have merit in the management of neurogenic dysphagia, the present study does not substantiate its effectiveness. “

There is insufficient evidence in the published, peer-reviewed scientific literature to conclude that electrical stimulation is effective in the treatment of dysphagia. Well-designed, randomized, controlled clinical trials are needed to demonstrate the effect and the clinical benefit of electrical stimulation for this condition.

Professional Societies/Organizations: The American College of Chest Physicians (ACCP) guidelines regarding cough and aspiration of food and liquids due to oral-pharyngeal dysphagia include a recommendation regarding electrical stimulation “for patients with muscular weakness during swallowing, muscle strength training, with or without electromyographic biofeedback, and electrical stimulation treatment of the swallowing musculature are promising techniques, but cannot be recommended at this time until further work in larger populations is performed” (Smith Hammond, et al., 2006).

Summary

Swallowing and feeding disorders may be a result of a wide variety of medical conditions. Swallowing therapy has been a standard of care that is used to treat this condition. Children with feeding disorders due to an underlying medical condition may be assisted with feeding therapy. Treatment of food aversion is considered behavioral and training in nature and not medically necessary. The goals of swallowing/feeding therapy include reducing aspiration, improving the ability to eat and swallow, and optimizing the nutritional status.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary:

CPT®*	Description
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92610	Evaluation of oral and pharyngeal swallowing function

ICD-9-CM Diagnosis Codes	Description
161-161.9	Malignant neoplasm of larynx
195.0	Malignant neoplasm of head, face, neck
235.0	Neoplasm of uncertain behavior of major salivary glands
235.1	Neoplasm of uncertain behavior of lip, oral cavity and pharynx
235.6	Neoplasm of uncertain behavior of larynx
434.0-434.91	Occlusion of cerebral arteries
435-435.91	Transient cerebral Ischemia
437-437.9	Other and ill-defined cardiovascular disease

438.82	Other late effects of cerebrovascular disease, dysphagia
783.3	Feeding difficulties and mismanagement
787.20-787.29	Dysphagia
V10.01	Personal history of malignant neoplasm of tongue
V10.02	Personal history of malignant neoplasm of other and unspecified parts of oral cavity and pharynx
V10.03	Personal history of malignant neoplasm of esophagus

Experimental/Investigational/Unproven/Not Covered when used to report electrical stimulation for swallowing/feedings disorders:

CPT* Codes	Description
97014	Application of a modality to one or more areas; electrical stimulation (unattended)
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes

HCPCS Codes	Description
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

*Current Procedural Terminology (CPT®) © 2010 American Medical Association: Chicago, IL.

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Policy History

Pre-Merger Organizations	Last Review Date	Policy Number	Title
CIGNA HealthCare	12/15/2008	0409	Speech Therapy for Swallowing and Feeding Disorders

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