



CIGNA MEDICAL COVERAGE POLICY

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

Subject Pediatric Intensive Feeding Programs

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Facilitated Communication
- Speech/Language Therapy
- Speech Therapy for Swallowing and
Feeding Disorders

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Coverage Policy

CIGNA does not cover pediatric intensive feeding programs because they are considered experimental, investigational or unproven.

General Background

Feeding disorders may occur frequently in early childhood. There is a reported incidence of minor feeding problems ranging between 25% and 35% in normal children, with more severe feeding problems observed in 40–70% of infants born prematurely or children with chronic medical conditions (Rudolph and Link, 2002).

Feeding and swallowing is a complex process that involves the mouth, pharynx, larynx and esophagus. 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 and Schecter, 1998). The mandible, maxilla, upper gums, lips, palate and cheeks are necessary for compression of the nipple and expression of contents. Any defect of lips, tongue, palate, mandible, maxilla or cheeks may create problems in the first phase of deglutition in an infant. 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 difficulty mastering them at a later point, leading to feeding problems.

In infants and children, the feeding and swallowing process includes the following phases (Rudolph and Link, 2002; Rudolph, 2003; American Speech-Language-Hearing Association [ASHA]):

- Pre-oral or oral preparatory phase: This phase includes introducing into the oral cavity.
- Oral phase: This phase consists of bolus formation and movement of food substance toward the pharynx by sucking or mastication of food.
- Pharyngeal phase: This phase involves triggering the swallowing reflex, squeezing the food down the throat and closing off the airway to prevent food or liquid from entering the airway or to prevent choking.
- Esophageal phase: This phase includes the relaxing and tightening of the openings at the top and bottom of the esophagus and squeezing food through the esophagus into the stomach.

Dysphagia and feeding problems are classified according to which phase of swallowing is affected. Oral dysphagia in children is seen most commonly in those with neurodevelopmental disorders (Darrow and Harley, 1998). These children will exhibit poor lingual and labial coordination. This will result in loss of food and a poor seal for sucking or removing food from a spoon. These children may also have difficulty with coordination of sucking, swallowing and breathing. Children with pharyngeal dysphagia may demonstrate the symptoms of oral dysphagia, along with coughing, gagging and choking with foods and liquids. However, the signs of pharyngeal dysphagia may be subtle. In this situation, the children may suffer from recurrent upper respiratory infections or have a history of pneumonia.

The most common signs and symptoms of feeding disorders and 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.

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 and Link, 2002):

Neurological disorders	<ul style="list-style-type: none"> • intracranial hemorrhage • myasthenia gravis • cerebral palsy • meningitis • encephalopathy
Disorders affecting suck-swallow-breathing coordination	<ul style="list-style-type: none"> • choanal atresia • bronchopulmonary dysplasia • cardiac disease • tachypnea
Structural lesions	<ul style="list-style-type: none"> • thyromegaly • cervical hyperostosis • congenital web • Zenker's diverticulum • ingestion of caustic material • neoplasm
Connective tissue disease	<ul style="list-style-type: none"> • polymyositis • muscular dystrophy
Iatrogenic causes	<ul style="list-style-type: none"> • surgical resection • radiation fibrosis • medications
Anatomic or congenital abnormalities	<ul style="list-style-type: none"> • cleft lip and/or palate • abnormalities of the tongue • velopharyngeal insufficiency

	<ul style="list-style-type: none"> • tonsillar hypertrophy • Pierre Robin sequence • laryngeal cleft • tracheoesophageal cleft • tracheoesophageal fistula • congenital esophageal atresia • esophageal stricture, web or ring
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Rommel et al. (2003) conducted a study for the purposes of characterizing the etiology of feeding difficulties in 700 children referred for assessment of severe feeding difficulty and to assess the prevalence of prematurity and dysmaturity in patients and their relationship to the type of feeding problems. The results indicated that close to 50% of the children had a combined medical and oral condition underlying their feeding difficulties; more than half of the children were examined for gastrointestinal conditions, in particular, gastroesophageal reflux disease. It was noted that behavioral problems were more frequently seen in children over two years old. The authors concluded that:

- A multidisciplinary team approach is essential for assessment and management because combined medical and oral problems are the most frequent cause of pediatric feeding problems.
- Infants born preterm and/or with a birth weight below the tenth percentile for gestational age are at greater risk for developing feeding disorders.

Evaluation of dysphagia and feeding disorders first includes performing a history and physical. Objectives of the history should include: identifying the anatomic region involved and obtaining clues to the etiology of the condition. This may include information regarding the onset, duration and severity, presence of regurgitation, the perceived level of obstruction and presence of pain or hoarseness, and presence of other disorders. 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 the evaluation of infants include: the Neonatal Oral-Motor Assessment Scale (NOMAS) and the Multidisciplinary Feeding Profile (MFP). Infants and children may require additional assessments, since growth, development, and changes in medical condition may affect the swallowing process.

The videofluorographic swallowing study (VFSS) is the gold standard for evaluating the mechanism of swallowing (Palmer, 2000). VFSS is also referred to as modified barium swallow. During this study, the patient will eat and drink foods mixed with barium while radiographic images are observed on a video monitor and recorded on videotape. Infants with adequate suck and swallow may be given liquid barium through nipple, or thin purees or tube feedings may be used (Darrow and Harley, 1998). This test is ideally 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). This test may also be used to test the effectiveness of compensatory maneuvers that are used to improve swallowing. This test cannot be performed on infants and children who are unable to swallow. In addition, infants and children with oral aversion and some feeding disorders may not ingest a sufficient amount of barium to provide a meaningful study (Rudolph, 2003).

Additional diagnostic testing that may be employed includes (Palmer, 2000; Darrow and Harley, 1998):

- Esophagoscopy: This test may be used to rule out neoplasm, particularly in patients who complain of thoracic dysphagia or odynophagia.
- Esophageal manometry and pH probe studies: These tests may be used when a motility disorder or gastric esophageal reflux disease is suspected.
- Electromyography: This test is indicated in patients with motor unit disorder such as polymyositis, myasthenia gravis, or amyotrophic lateral sclerosis.
- Fibroptic endoscopic examination of swallowing (FEES): This test is performed with a transnasal laryngoscope to assess pharyngeal swallowing. This test may be helpful when a VFSS is not feasible.

- Ultrasound imaging: This testing has been used to a limited extent on infants to assess the oral phase of swallowing. The technique is limited to infants, since teeth will interfere with the sound signal. This method will permit studying of infants during breast-feeding, since contrast media is not required.

When possible, initial treatment is aimed at the underlying cause of dysphagia. Depending on the underlying cause, surgery or pharmacological therapy may be used. However, the causes of many of the disorders resulting in feeding disorders or dysphagia may not be amenable to pharmacological therapy or surgery as a result of behavioral contributors to impairment. In these cases, a referral to a professional, such as a speech pathologist, or feeding clinic is appropriate. A child may continue with signs and symptoms of a feeding disorder even after correction of an underlying abnormality due to a learned aversion to feeding. In these cases, behavior therapy may be considered.

Prerequisites for oral feeding attempts for infants and young children include (Arvedson 1998):

- cardiopulmonary stability
- alert, calm state
- in young infants, demonstration of rooting responses and adequate non-nutritive sucking
- appetite or observable interest in eating

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 adjustments 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.

Esophageal phase swallow disorders are generally not amenable to oral-motor and swallow therapy. Positioning changes, changes in food characteristics and timing may make a difference.

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 (American Cleft Palate-Craniofacial Association [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

When a patient is unable to achieve adequate alimentation and hydration by mouth, enteral feedings through a nasogastric tube or a percutaneous endoscopic gastrostomy 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.

Management of feeding and swallowing problems in children and infants is often handled through a multidisciplinary approach. Management of the condition may incorporate nutrition recommendations, medical and surgical decisions, position guidelines, oral-motor swallow practice and behavioral intervention (Arvedson, 1998).

Therapy provided for feeding disorders should have a documented plan of care that includes specific measures that will be used to assess progress, and objective long- and short-term goals. Assessment of progress toward goals should be made on a regular basis, approximately every 4–6 weeks. Goals should be reevaluated and may be revised depending on progress and the patient's condition.

Pediatric Intensive Feeding Programs

Pediatric intensive feeding programs are interdisciplinary programs that have been proposed to provide treatment for patients with impairment of oral intake. These programs combine medical and behavioral health techniques and provide these services on an intensive basis. The multidisciplinary services may include gastroenterology, behavior psychology, nutrition, social work, occupational therapy, sensory integration, and speech and language therapy. The website for one of these programs, the Marcus Institute feeding program, states that “a pediatric feeding disorder is diagnosed when children fail to consume an adequate quantity or quality of solids or liquids to sustain growth.” Examples of feeding disorders that are treated in these programs include the following:

- oral motor dysfunction (e.g., dysfunctional, dysphagia, oral motor dysphagia)
- food refusal/selectivity
- failure to thrive
- short gut syndrome
- gastrointestinal disorders
- self-feeding deficits
- feeding tube dependent

These programs may be provided on an inpatient basis or daily outpatient basis, which is also referred to as a day feeding program. The inpatient programs are generally recommended for children with severe feeding difficulties who may require around-the-clock medical supervision. The Kennedy Krieger Institute website for their pediatric feeding disorders unit states that, “Inpatient services are recommended for children with severe feeding difficulties (e.g., failure-to-thrive, vomiting, G-tube dependence, total food refusal) so that close medical assessments, nutritional monitoring, oral motor assessments and intense behavioral interventions can be conducted.” The day program is typically provided eight hours a day, five days per week, and involves feeding sessions of 3–5 meals a day. Between feeding sessions, the patient may be involved in other therapies if needed, playroom, naps or school activities. The day program typically lasts approximately 4–8 weeks.

Literature Review

While a multidisciplinary approach may be needed in the management of feeding disorders in infants and children, a review of the published medical literature indicates that there is insufficient evidence to support the use of pediatric intensive feeding programs to treat swallowing and feeding problems in children.

A review of the literature was performed by Miller and Willging (2003) regarding research efforts for diagnostic and treatment strategies for pediatric dysphagia. It was noted that “there is little in the way of outcomes research regarding the effectiveness of diagnostic procedures and management techniques.” It was noted that most pediatric dysphagia diagnostic and management protocols are based on assumptions and anecdotal evidence. The authors concluded that continued research is needed to prove the reliability and validity of evaluation and management techniques. In addition, they noted that patient outcomes differentiated by diagnosis needed to be tracked to establish evidence-based practice standards for management of pediatric dysphagia.

Byars et al. (2003) conducted a prospective clinical trial for the purpose of describing outcomes in nine children with Nissen fundoplication and feeding gastrostomy (G-tube) treated in a multicomponent intensive feeding program. Nine children with a history of behavioral feeding resistance and G-tube dependence were admitted for intensive treatment to an inpatient feeding program. The treatment included short-term behavioral treatment with a family-focused approach. A team of behavioral therapists managed all aspects of behavioral treatment. A gastroenterologist and registered dietician monitored and managed the medical and nutritional status. At discharge, it was reported that 44% of the sample had been successfully weaned from gastrostomy feedings. At follow-up, six of the nine patients (67%) were weaned from G-tube feeding and taking 100% of their nutritional needs by mouth. It was noted that range of inpatient treatment was 5–16 days. Follow-up assessment was obtained in a clinic visit scheduled 2–4 months after the child's discharge from the program. Three families did not return for the follow-up visit due to distance from the facility. Weight gains were noted to be small.

Limitations of the study included no control group, the small group size and the length of follow-up time after the study.

Summary

Dysphagia and feeding disorders in children and infants may be a result of a wide variety of medical conditions. Multidisciplinary care may be needed to treat these conditions. Dysphagia/feeding therapy has been a standard of care that is used to treat this condition. There is insufficient evidence in the published peer-reviewed medical literature to support the use of inpatient or outpatient comprehensive multi-disciplinary pediatric intensive feeding programs to treat swallowing and feeding problems in children. Impact on health outcomes has not been demonstrated through well-designed clinical trials. The role of these programs in the management of swallowing and feeding problems has not been established.

Coding/Billing Information

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

Experimental/Investigational/Unproven/Not Covered:

CPT* Codes	Description
	No specific codes

HCPCS Codes	Description
	No specific codes

ICD-9-CM Diagnosis Codes	Description
	Multiple/Varied

*Current Procedural Terminology (CPT®) © 2007 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	0422	Pediatric Intensive Feeding Programs

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