KAISER PERMANENTE®

Review Criteria
Georgia Region

Title:	**Intensive Inpatient Feeding Disorder Program (PEDIATRIC FEEDING DISORDERS)**		
Department:	QUALITY RESOURCE MANAGEMENT	**Page:**	1 of 5
Section:	UTILIZATION MANAGEMENT	**Policy Number:**	01-16
Type:	( ) New	**Effective Date:**	06-03
	(X) Reviewed / Revised	**Date:**	2/13/2017 1/29/2018 2/8/2019 1/30/2020 1/25/2021 1/19/2022 2/28/2023

Purpose
This policy provides the indications and contraindications necessary for the Quality Resource Management staff to make the most appropriate decision related to the medical necessity of the procedure listed.

DIAGNOSIS ICD-9 CODE AND DESCRIPTION:
DIAGNOSIS/CONDITION: Feeding Disorder and/or food aversion, secondary to medical, physiologic and/or behavioral problems, Avoidant Restrictive Food Intake Disorder

CPT-4/ HCPCS CODE AND DESCRIPTION: 92526

INDICATIONS
- Food aversion or other feeding disorders in children

1.0 STANDARD CHECKLIST

A. Documentation of the initial treatment program and the child's response to that program should be included in the request for referral to a more intensive program.

B. The child has an inability or refuses to eat or drink and therefore has inadequate nutritional intake.

C.The child's weight (or BMI%) continues to decrease or does not increase.

D.The child requires tube feedings to grow.

E. The child may exhibit inability to chew or swallow.

F. The child has chronic vomiting or regurgitation.

G. The child exhibits inappropriate mealtime behavior as an end result.

H. Progress can be expected within a 60-day treatment plan.

2.0 VIEW OF THE SOUTHEAST PERMANENTE MEDICAL GROUP

Feeding or food aversion disorders can initially be adequately assessed by the primary Pediatrician. Because feeding problems are complex and multifactorial in nature it is often necessary to have several disciplines providing intervention to one child at any given time. **Consultation with a Pediatric Gastroenterologist, Behavioral Health as well as consultation with Physical Therapy, Occupational Therapy and Speech Therapy at Children's Health Care of Atlanta should be utilized to assess the feeding problem and devise a treatment program. These evaluations must be completed prior to referral to the Marcus Center**.

Children who fail these treatment program may then be considered for a more intensive rehabilitation program. Marcus Center offers treatment for feeding disorders. Patients can be reviewed for a referral to Marcus on a case-by-case basis, if all other treatment options have been exhausted. This requires QRMMD review.

3.0CLINICAL SUMMARY:

Feeding disorders in children may result from a complex multifactorial interaction between medical, physiologic, behavioral and developmental problems.

Presenting symptoms include food refusal, oral aversion, failure to thrive, recurrent pneumonia, chronic lung disease, or recurrent emesis. A medical problem, such as GER, can manifest as a behavioral problem with refusal to eat because of pain. Anatomic or functional disorders can make feeding difficult or uncomfortable resulting in a learned aversion to eating. Delays in initiation of feeding caused by underlying disorders may affect the acquisition of feeding skills, even after the disorder has been resolved. Limited oral/food intake results in failure of normal development and the failure of oral motor responses to develop normally. Treatment of failure to eat may require a multidisciplinary team approach to treatment. The team can include the disciplines of speech pathology, occupation therapy, psychology or psychiatry, nutrition, gastroenterology, otolaryngology, neurology, pulmonary, radiology and social service.

Because problems with feeding may lead to significant negative nutritional, developmental and psychological sequelae and because the severity of these sequelae is related to the age at onset, degree and duration of the feeding problem, early recognition and management are important.

3.2 **Causes of Feeding Disorders:**

A. Disorders that affect appetite, food-seeking behaviors and ingestion such as depression, deprivation, sensory integration disorders, and Autism

B. Sensory defects such as anosmia

C. Aversions due to prior long term parenteral or enteral feedings

D. Metabolic Disorders such as phenylketonuria, fructose intolerance, acidemias, urea cycle disorders

E. Conditioned Dysphagia such as GER, aspiration, fatigue

F. Anatomic abnormalities of oropharynx; cleft lip/palate, choanal atresia

G. Craniofacial birth defects such as Treacher and Robin Sequence syndromes, also referred to as Pierre Robin sequence or syndrome.

G. Anomalies of the Esophagus such as tracheoesophageal fistula, atresia, stricture

H. Disorders of Suck-Swallow-Breathing coordination such as cardiac disease, lung problems, bronchopulmonary dysplasia, cystic fibrosis

I. Neuromuscular disorders such as CP, muscular dystrophies, collagen vascular diseases

J. Disorders of Esophageal Peristalsis such as achalasia, collagen vascular diseases

K. Other Disorders that can affect feeding such as Rett syndrome, Trisomy 21(Down Syndrome), Fragile X Syndrome, Xerostomia, Hypothyroidism

L. Traumatically acquired conditioned dysphagia and post-traumatic feeding disorder –

which can occur from repeated exposure to noxious substances, experiences or procedures (e.g., choking, vomiting, forced feeding, repeated suctioning or insertion of tubes for feeding) in and around the mouth. The prevalence of these types of feeding problems may be on the rise because advances in medical technology enable more children with severe illnesses to survive.

3.3 **Evaluation:**

The evaluation after a complete physical and includes:

A. Health history - A review of the child's health history provides information about medical conditions that may contribute to feeding and/or swallowing problems, exam: Cerebral Palsy

B. Growth history

C. Developmental history

D. Focused feeding history

E. Textures, routes of feeding

F. Time it takes to feed.

G. Frequency of feeding attempts

H. Feeding positions specific food aversion

It is important to identify infants and young children with swallowing dysfunction. These young children may have an inability to protect their airway during feeding, thus rendering oral feeding unsafe. Symptoms of swallowing dysfunction may include history of recurrent pneumonias, respiratory illnesses, slow feeding, oral or nasal regurgitation, gagging, choking, or coughing before and/or during the swallow. When swallowing dysfunction is suspected, further clinical and laboratory evaluation is necessary to ensure a safe swallowing mechanism.

History of the following may be significant:

A. Recurrent pneumonia or respiratory illnesses

B. Stridor with feeding

C. Snoring

D. Swallowing difficulties/dysfunction

E. Pain with eating

F. Oral or Nasal Regurgitation

4.0 REFERENCES:

- Rudolph, Colin D. MD, Thompson, Dana MD, MS; “Feeding Disorders in Infants and Children, “Pediatric Clinics of North America; Vol. 49, No 1, February 2002
- Robb, Adelaide MD; “Eating Disorders in Children, Diagnosis and Age-Specific Treatment, “Psychiatric Clinics of North America; Vol. 24, No. 2, June 2001
- Debby Arts-Rodas, RD and Diane Benoit, MD FRCPC; “Feeding problems in infancy and early childhood: Identification and management”; Pediatric Child health 1998 Jan-Feb; 3(1): 21–27.
- Neonatal Oral Feeding Difficulties due to Sucking and Swallowing Disorders; Up To Date , Literature review current through: Jan 2019. | This topic last updated: Jun 15, 2017

Approval

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