Molina Clinical Policy
Speech Therapy for Feeding Disorders: Policy No. 269

Last Approval: 12/11/2024
Next Review Due By: December 2025

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

Speech Language Pathology (SLP) services are defined by the American Speech Language Hearing Association (ASHA) as those necessary for the diagnosis and treatment of swallowing, speech-language, and cognitive-communication disorders that result in communication disabilities. Speech disorders include:

- Sound production (e.g., articulation, apraxia, dysarthria)
- Resonance (e.g., hypernasality, hyponasality)
- Voice (e.g., phonation quality, pitch, respiration)
- Fluency (e.g., stuttering)
- Language (e.g., comprehension, expression, pragmatics, semantics, syntax)
- Cognition (e.g., attention, memory, problem solving, executive functioning)
- Feeding and swallowing (e.g., oral, pharyngeal, and dysphagia)

Speech-language pathologists (SLPs) specialize in the evaluation and treatment of communication and swallowing disorders and work with individuals who have physical or cognitive deficits/disorders resulting in difficulty communicating. Speech therapy services are classified as either rehabilitative or habilitative. Rehabilitative services aid in the restoration or enhancement of abilities that have been lost or impaired because of illness. Habilitative services are intended to maintain, develop, or improve skills that have not (but would normally have) developed or are at risk of being lost because of illness, injury, loss of a body part, or congenital abnormality (ASHA 2015).

Pediatric Feeding Disorders (PFDs) refer to any challenge an individual experiences with eating or drinking compared to peers of the same age. PFD is linked to difficulties in medical, nutritional, feeding skill, or psychological areas. When a person has impaired oral intake, they are unable to consume enough food and fluids to meet their nutritional and hydration needs. These impairments can lead to restrictions in daily activities and participation, influenced by individual and environmental factors (ASHA n.d.) Symptoms of feeding disorders may include extreme food selectivity, food refusal, failure to thrive, oral aversion, and recurrent emesis. Anatomical or functional disorders that make feeding difficult or uncomfortable for the child may result in a learned aversion to eating even after the underlying disorder is corrected. Children with developmental disabilities are more likely to develop feeding-related difficulties such as gastroesophageal reflux, oral motor dysfunction, and aversive feeding disorder.

Avoidant/Restrictive Food Intake Disorder (ARFID) is an eating disorder marked by restrictive eating that leads to one or more serious health issues, such as poor growth or weight loss, nutrient deficiencies, reliance on nutritional supplements, or major social and emotional difficulties due to limited food intake (King & Duryea 2024). Individuals with ARFID restrict the amount or variety of food they consume due to a lack of interest in eating, sensory sensitivities to taste, texture, or smell, or a fear of negative outcomes, such as vomiting or choking.

Given the complexity of PFDs and ARFIDs a multidisciplinary approach is often essential. SLPs play a crucial role in assessing whether a child has difficulty eating due to physical limitations or behavioral factors. They work closely with the team to develop and implement effective interventions. Collaboration between SLPs, psychologists, behavioral specialists, and the child's parents or caregivers is vital in achieving therapeutic goals and advancing treatment progress (Gosa et al. 2020).

COVERAGE POLICY

Please review all applicable State and Federal mandates and health plan regulations before applying the criteria below. Refer to requirements, criteria, and guidance provided by the State in which the Member is receiving treatment, as the State's documents will supersede this Molina Clinical Policy.

This policy does not address Dysphagia Rehabilitation or Speech Therapy unrelated to feeding disorders.

Initial Speech Language Therapy Criteria

Speech Language Pathology (SLP) Therapy for the treatment of pediatric feeding disorders may be **considered medically necessary** when there is an expectation that speech therapy will achieve a measurable improvement in the Member's condition in a reasonable and predictable period of time, and **ALL** the following criteria are met:

1. Member is less than 18 years of age

2. Member meets at least **ONE** of the following:
   a. Weight loss, poor growth, or failure to thrive/achieve expected weight gain
      i. Failure to Thrive / Weight Loss: Unresponsive to standard age-appropriate interventions over four weeks with clinical signs and symptoms of nutritional risk from failure to thrive as indicate by the following for neonates, infants, and children < 18 years of age
         1. Weight, height, or BMI age ≤ 10 percentile
         2. Crossed (downward) at least 2 percentile lines of weight for age on the growth chart
   b. Nutritional deficiency
   c. Impaired psychosocial functioning
   d. Oral motor dysfunction (e.g., problems swallowing due to central nervous system (CNS) or neuromuscular disorders)

3. Services require the judgment, knowledge, and skills of a qualified provider of SLP services due to the complexity of the therapy and the medical condition of the Member

4. Services must be provided in accordance with an ongoing, written plan of care that is reviewed with and approved by the treating physician in accordance with applicable state laws and regulations. Documentation should include **ALL** the following:
   a. Clinical data to support medical necessity of treatment
   b. Speech therapy evaluation
   c. Specific and measurable short- and long-term goals with reasonable time estimate to achievement
   d. Frequency and duration of treatment
   e. Techniques/exercises to be used in treatment

Continued Therapy

Continued therapy for food aversion may be **considered medically necessary** when **ALL** the following are met:

1. Member still meets definition of failure to thrive or nutritional deficiency

2. Member has shown improvement in oral intake (quantity and/ or variety)

3. Member has shown improvement in weight and/or nutritional status

4. Member and/or caregiver committed to program participation including adherence to carryover exercises

Limitations and Exclusions

All other treatment requests that do not meet the above criteria are considered **NOT medically necessary or**

experimental, investigational, and unproven, including but not limited to:

1. Duplicate therapies of the same treatment from two different rehabilitative providers (e.g., occupational or physical therapy in conjunction with speech therapy)
2. Long term rehabilitative services when significant therapeutic improvement is not expected
3. Maintenance therapy when no additional functional progress is being made, unless a change in status occurs that would require a re-evaluation
4. Therapy is being provided to meet developmental milestones and/or is provided by the Member's school district or other State benefit
5. Therapy that does not require the skills of a qualified provider of speech therapy services, such as treatments which maintain function and are neither diagnostic nor therapeutic, or procedures that may be carried out efficiently by the patient, family, or caregivers in the home

DOCUMENTATION REQUIREMENTS. Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

There is limited published peer-reviewed literature on the effectiveness of speech therapy for the treatment of feeding disorders. The published evidence consists of systematic reviews, meta-analyses, retrospective reviews, and case studies that focus on multidisciplinary interventions. However, there are no universal guidelines on the number of speech therapy treatments for any diagnosis, nor is there consistent evidence based on any diagnosis on which to base a treatment decision.

Systematic Reviews and Meta-Analyses
Sharp et al. (2017) conducted a systematic review and meta-analysis of 11 studies, covering 593 children (ages 15.7-48 months; 314 boys and 279 girls), to evaluate outcomes of intensive, multidisciplinary interventions for pediatric feeding disorders. Eligible studies presented quantitative data on food intake, feeding behavior, and growth before and after treatment, typically conducted in day or inpatient hospital settings with a team including psychology, nutrition, medicine, and speech language pathology/occupational therapy. Most children (n = 535; 90.2%) were treated for feeding tube dependence, with many also managing coexisting medical issues like gastroesophageal reflux, failure to thrive, and other unspecified GI concerns. Despite variations in specific outcome measures, all studies tracked improvements in oral food consumption. Eight studies reported weaning rates from enteral feeding, six examined calorie intake from oral versus enteral sources, and three used direct observation to assess mealtime behavior. Results indicated that 69.8% of children were weaned from enteral feeds and 74.5% of children showed improved oral intake. The studies that included direct observation reported significant gains in bite acceptance, swallowing, and reduced disruptive behaviors. Overall, the review supports the effectiveness of intensive, multidisciplinary care for children with complex feeding disorders.

Non-Randomized Studies, Retrospective Reviews, and Other Evidence
Sharp et al. (2020) performed a five-year retrospective study of children (ages birth to 21) in a multidisciplinary feeding intervention program. The program team included various specialists—psychologists, physicians, nurse practitioners, dietitians, speech-language pathologists, occupational therapists, and social workers—who provided integrated care combining behavioral and nutrition therapy, parent training, and medical oversight. Patients were eligible if they relied on enteral feeding, had poor oral intake, and were medically stable for tube weaning. The study analyzed 81 participants (46 males, 35 females, aged 10-230 months), all with complex feeding challenges and developmental or behavioral histories. Primary outcomes included changes in oral intake and weaning success rates from tube feeding. Upon discharge, patients' calorie intake through oral feeding improved by an average of 70.5%, and 33% of participants were fully weaned from tube feeding. Patients showed significant progress in eating behaviors, with a 91.3% increase in rapidly accepted bites, a 99.1% improvement in mouth cleanliness during meals, and a 68.4% reduction in disruptive mealtime behaviors. At follow-up, 72% (58 patients) had achieved full tube weaning. Study limitations included its observational nature, limiting causation claims. Data relied on electronic health records, lacking specific details on oral-motor skills, daily living functions, and mealtime behavior. Despite these limitations, the findings suggest that an

intensive multidisciplinary approach can effectively increase oral intake and reduce tube dependency in children with chronic feeding issues.

Mattingly et al. (2015) conducted a case study on managing feeding aversion in a 9-month-old child diagnosed with Food Protein-Induced Enterocolitis Syndrome (FPIES). The treatment plan focused on speech-language pathology interventions including food play, the introduction of safe hypoallergenic formulas, and sequential presentation of foods like pears in varied forms, textures, and environments, with a slower-than-usual one- to two-week introduction period. Key outcome measures included reductions in feeding aversion, increased flexibility with food items, acceptance of varied food presentations, and reduced dependence on breastfeeding. Results showed that while the child initially rejected elemental formulas, she eventually demonstrated progress in food interaction, especially in accepting new foods and reduced oral aversion. Limitations of the study included its single-patient focus and challenges in generalizing findings to other FPIES patients due to individualized needs and responses. Overall, the study demonstrates that by integrating speech-language therapy techniques with medically safe food exposure, clinicians can support FPIES patients in overcoming feeding aversion and advancing their oral motor development.

National and Specialty Organizations

The **American Speech Language Hearing Association (ASHA)** published *Speech-Language Pathology Medical Review Guidelines* to provide an overview of standard practices, descriptions of services, documentation of services, medical necessity of services, and treatment data. The guidelines provide an overview of the prevalence and incidence of communication and swallowing disorders. The ASHA outlines medical necessity of speech-language pathology services and indications for treatment. Information in the publication is updated on an as-needed basis.

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology)

Code	Description
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria);
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92526	Treatment of swallowing dysfunction and/or oral function for feeding

HCPCS (Healthcare Common Procedure Coding System

Code	Description
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes
S9128	Speech therapy, in the home, per diem
S9152	Speech therapy, re-evaluation

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

12/11/2024	Policy reviewed. Policy name changed to 'Speech Therapy for Feeding Disorders'. Updated Coverage Criteria, Summary of Medical Evidence, and References. IRO peer review
12/13/2023	Policy reviewed, no changes to criteria. Updated Summary of Medical Evidence and References.
12/14/2022	Policy reviewed, no changes to criteria. Updated Summary of Medical Evidence and References.
12/08/2021	Policy reviewed, reorganized Coverage Policy section, updated Summary of Medical Evidence and References. IRO peer review by a board-certified speech pathologist.
04/05/2021	Policy reviewed, no changes to criteria. References updated.
04/23/2020	Policy reviewed, no changes to criteria. References updated.
06/19/2019	Policy reviewed, no changes to criteria. References updated.
03/08/2018	Policy reviewed, no changes to criteria. References updated.

REFERENCES

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3. Gosa MM, Dodrill P, Lefton-Greif MA, et al. A Multidisciplinary Approach to Pediatric Feeding Disorders: Roles of the Speech-Language Pathologist and Behavioral Psychologist. Am J Speech Lang Pathol. 2020 Jul 10;29(2S):956-966. doi: 10.1044/2020_AJSLP-19-00069. Epub 2020 Jul 10. PMID: 32650658.
4. King K., Duryea T. Poor weight gain in children older than two years in source-abundant settings. Updated October 17, 2024. Accessed November 13, 2024. http://www.uptodate.com.
5. Mattingly R, Mukkada V, Smith A, et al. Optimizing an Aversion Feeding Therapy Protocol for a Child with Food Protein-Induced Enterocolitis Syndrome (FPIES). J Pulm Respir Med. 2015 Aug;5(4):287. doi: 10.4172/2161-105X.1000287. Epub 2015 Aug 25. PMID: 26779390; PMCID: PMC4712946.
6. Sharp WG, Volkert VM, Scahill L, et al. A Systematic Review and Meta-Analysis of Intensive Multidisciplinary Intervention for Pediatric Feeding Disorders: How Standard Is the Standard of Care? J Pediatr. 2017 Feb;181:116-124.e4. doi: 10.1016/j.jpeds.2016.10.002. Epub 2016 Nov 8. PMID: 27843007.
7. Sharp WG, Volkert VM, Stubbs KH, et al. Intensive Multidisciplinary Intervention for Young Children with Feeding Tube Dependence and Chronic Food Refusal: An Electronic Health Record Review. J Pediatr. 2020 Aug;223:73-80.e2. doi: 10.1016/j.jpeds.2020.04.034. Epub 2020 Jun 9. PMID: 32532645.

APPENDIX

Reserved for State specific information. *Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.*

Washington
For Medicaid, therapy past No-Authorization-Needed (NAN) visits would be subject to WAC Limitation Extension review and MCP could be used for medical necessity guidance in that case.