FirstChoice VIP CARE
by Select Health of South Carolina

Pediatric Intensive Feeding Programs

Clinical Policy ID: CCP.1322

Recent review date: 2/2026

Next review date: 6/2027

Policy contains: Feeding disorder; pediatric intensive feeding program.

FirstChoice VIP Care has developed clinical policies to assist with making coverage determinations. FirstChoice VIP Care's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered, on a case by case basis, by FirstChoice VIP Care when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. FirstChoice VIP Care's clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. FirstChoice VIP Care's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, FirstChoice VIP Care will update its clinical policies as necessary. FirstChoice VIP Care's clinical policies are not guarantees of payment.

Coverage policy

Pediatric intensive feeding programs (outpatient and inpatient) are clinically proven and, therefore, may be medically necessary when all of the following criteria are met (American Speech-Language-Hearing Association, 2024):

- Member has a diagnosed feeding disorder defined as a medical, nutritional, feeding skill, or psychosocial impairment that interferes with age-appropriate oral intake and the ability to meet nutritional and hydration requirements (Goday, 2019).
- The feeding program is a multidisciplinary team led by a physician.
- An individualized treatment plan has been submitted that includes child-specific interventions and goals, an estimated length of treatment, and active participation/involvement of a parent or guardian.
- The member is medically stable.
- The member is capable of participating in the program.
- Any contributing underlying condition has been or is being addressed without resolution of the feeding problem.

An inpatient pediatric intensive feeding program is clinically proven and, therefore, may be medically necessary when all of the above criteria are met and an outpatient pediatric intensive feeding program has failed or is contraindicated (American Speech-Language-Hearing Association, 2024).

Continuation of outpatient or inpatient pediatric intensive feeding program services beyond the original determined length of treatment (as specified in the treatment plan) may be medically necessary when either condition has been met:

- New clinical findings or a change in the member's condition interferes with feeding.
- The member has demonstrated continued improvement but has not met the established treatment goals in the treatment plan.

Limitations

Pediatric intensive feeding programs are investigational/not clinically proven and, therefore, not medically necessary:

- For treating childhood obesity.
- For mild to moderate feeding difficulties in members whose normal growth and developmental milestones are being met.
- To prevent recurrence of the feeding disorder.
- To improve or maintain the member's general physical condition.
- When the treatment goals established in the treatment plan have been met.

Alternative covered services

Routine patient evaluation and management by a network healthcare provider.

Background

Goday (2019) proposed a unified definition for pediatric feeding disorder, based on a World Health Organization framework of International Classification of Functioning, Disability, and Health, as "impaired oral intake that is not age-appropriate, and is associated with medical, nutritional, feeding skill, and/or psychosocial dysfunction." Impairment in any one of the four domains can lead to dysfunction in any of the others. In this case, impaired oral intake refers to the inability to consume sufficient food and liquids to meet nutritional and hydration requirements.

Feeding and swallowing concerns are often medically complicated. Frequently, therapy is provided by a multidisciplinary team including, but not limited to, speech, occupational, and physical therapists, dietitians, pediatricians, and pediatric psychologists (Toomey, 2026). One model classifies child eating behaviors into categories of limited appetite, selective intake, and fear of feeding. Each category includes a range from normal (misperceived) to severe (behavioral and organic) (Kerzner, 2015).

Another behavioral framework for pediatric feeding includes behavioral assessment, treatment planning, questionnaire, family clinical interview, mealtime observations, behavioral treatment, environmental interventions, and increasing desirable/decreasing undesirable feeding behavior (Silverman, 2015).

Some pediatric feeding problems are linked to particular disorders. There is a high occurrence of feeding challenges in children diagnosed with autism spectrum disorders (Silbaugh, 2016). Several investigations document elevated risk for feeding-related disorders when individuals experience chronic medical conditions requiring diet management, such as diabetes, cystic fibrosis, celiac disease, gastrointestinal disorders, and inflammatory bowel diseases (Conviser, 2018), and oromotor feeding impairments in children with neurobehavioral issues (Sanchez, 2017).

Intensive, multidisciplinary intervention for pediatric feeding disorders has become an important treatment approach for infants and children exhibiting this disorder. A typical pediatric intensive feeding program may draw from the disciplines of psychology, nutrition, medicine, speech-language pathology and occupational therapy; and assert goals as elementary as weaning from tube feeding to achieving complex behavioral modification. An intensive program is defined by its daily, scheduled and clearly defined therapeutic intervention as opposed to routine "as needed" adjunctive therapy applied intermittently or sporadically as part of routine patient evaluation and management by a healthcare provider. These programs may be offered in inpatient or outpatient settings. The outpatient setting is generally preferred, reserving the inpatient setting for more severe conditions requiring around-the-clock medical supervision (American Speech-Language-Hearing Association, 2024).

Findings

Guidelines

The American Speech-Language-Hearing Association (2024) emphasized the integral role of speech-language pathologists as the primary providers of dysphagia services and as essential members of collaborative teams managing complex pediatric feeding concerns. Individualized treatment plans should align with the International Classification of Functioning, Disability, and Health framework and be delivered in settings ranging from hospital to outpatient to home or school. In instances where individuals have moderate to severe feeding challenges yet remain medically stable, inpatient services may be appropriate if these individuals require or are at risk for feeding tubes, exhibit restricted food choices, or do not respond to outpatient methods.

Evidence review

Systematic reviews

Early identification and accurate evaluation of pediatric feeding disorders are essential for improving outcomes. Several systematic reviews have identified multiple measurement tools used to assess feeding behaviors, but these instruments lack rigorous supportive evidence of validity and reliability to evaluate pediatric feeding disorders and treatment effectiveness across studies (Campbell, 2025; Cardoso, 2025; Jaafar, 2019).

Numerous investigations of treatments for children with feeding disorders suffer from limited sample sizes and ambiguous definitions of problematic behaviors and outcomes. However, some larger bodies of work clarify the efficacy of intensive and multidisciplinary approaches.

From 11 studies, Akyurek (2026) identified behavioral approaches and systematic desensitization approaches, sensory games, repeated exposure, and parent trainings as promising interventions for pediatric sensory-behavioral feeding problems. The authors recommended larger interventional studies with long-term follow up to confirm the findings.

In children with cerebral palsy, a review of seven randomized controlled trials (n = 329 participants ages 9.5 months to 10.6 yrs) found combinations of behavioral interventions were beneficial in treating oropharyngeal dysphagia. However, the evidence was of low quality, and the true effects of behavioral interventions across the developmental phase of childhood cannot be determined (McInerney, 2025).

One systematic review included 11 studies of 593 participants with chronic food refusal, treated in day programs or inpatient hospital settings (Sharp, 2017). The most prevalent interventions were behavioral therapy and tube weaning, and results showed that 71% of these participants were successfully weaned from feeding tubes. Follow-up indicated 80% remained tube-free, accompanied by improved oral intake, more positive mealtime interactions, and decreased caregiver stress.

Other reviews concentrate on specific behaviors and populations. A synthesis of studies of food packing highlighted the importance of identifying whether packing is driven by a physical motor challenge (e.g.,

swallowing issues) or by performance-related barriers (Silbaugh, 2018). A broad systematic review of 106 randomized controlled trials, involving 16,448 participants, evaluated methods to prevent disordered eating, supporting the broader use of proven interventions such as cognitive behavioral therapy for targeted groups (Watson, 2016).

Research on feeding problems in children diagnosed with autism spectrum disorders identifies both a high occurrence of feeding challenges and the general success of behavioral approaches in boosting acceptance and swallowing of target foods, although methodological inconsistencies complicate judgments regarding the durability of these outcomes (Silbaugh, 2016). An additional review of 21 observational studies and one randomized trial showed that short breastfeeding duration and certain early weaning methods correlate with elevated risks of food refusal, pickiness, and neophobia in children older than one year (Babik, 2021).

Meta-analyses

Some evidence syntheses have proceeded beyond systematic review to meta-analysis, illuminating further intervention effects. One meta-analysis analyzed 23 small-scale studies (fewer than five participants each) intended to enhance feeding behaviors in children with autism spectrum disorders (Marshall, 2015). The findings showed medium-to-large improvements in volume consumed but negligible changes in variety. Another meta-analysis of 14 articles investigated feeding interventions for young persons in poverty, indicating modest general effects that grew when measured long term (Pastor, 2020).

A comprehensive systematic review and meta-analysis of the effect of caregiver training on child feeding behaviors included eight articles with a total of 575 participants from three countries, and seven of those articles contributed data to meta-analyses (Madonna, 2025). There was high-certainty evidence that caregiver training boosted child feeding behaviors and moderate-certainty evidence that maladaptive mealtime strategies decreased, though questions remained about the optimal frequency and duration of such programs. Caregiver stress and dietary consumption outcomes varied but trended positively in certain investigations.

In preterm infants, an analysis of 11 studies of fair-to-high quality evidence found that unimodal sensorimotor stimulation protocols combined with non-nutritive sucking was more effective than usual care in decreasing time transition to full oral feeding, improving feeding efficacy, and shortening hospital length of stay, but not in improving weight gain (Muñoz-Gómez, 2024).

A second meta-analysis examined 38 studies with a total of 98 participants and found the strongest outcomes for mealtime problem behavior reduction and favorable feeding behaviors resulted from a combination of extinction-based and non-extinction-based techniques (Scott, 2024). Exclusively non-extinction interventions were faster on average but less robust. Many of the included studies did not fully address follow-up, generalization to other settings, or measures centered on caregivers, highlighting areas that require additional research to determine which interventions offer the most sustained benefits.

In 2025, the findings section of this policy was condensed and rearranged thematically. No policy changes were made.

In 2026, we updated the references with no policy changes warranted.

References

On January 9, 2026, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “Feeding and Eating Disorders of Childhood” (MeSH), “Intensive feeding,” “Failure to thrive,” “feeding aversion,” “swallowing dysfunction,” “malnutrition,” “feeding programs,” “premature infant feeding.” We included the best available evidence according to established

evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

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Policy updates

7/2017: initial review date and clinical policy effective date: 8/2017

7/2018: Policy references updated.

9/2019: Policy references updated. Policy ID changed to CCP.1322.

9/2020: Policy references updated.

9/2021: Policy references updated.

9/2022: Policy references updated.

1/2023: Policy references updated. Coverage modified.

1/2024: Policy references updated.

2/2025: Policy references updated.

2/2026: Policy references updated.

Related Codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy CCP.1322. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

Code	Code Description
99199	Unlisted special service, procedure or report