TITLE: OUTPATIENT ENTERAL NUTRITION THERAPY

EFFECTIVE DATE: June 15, 2020

This policy was developed with input from specialists in gastroenterology, general surgery, internal medicine and pediatrics and endorsed by the Medical Policy Committee.

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY
These services may or may not be covered by all Medica plans. Please refer to the member’s plan document for specific coverage information. If there is a difference between this general information and the member’s plan document, the member’s plan document will be used to determine coverage. With respect to Medicare and Minnesota Health Care Programs, this policy will apply unless these programs require different coverage. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Medica utilization management policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

Medica utilization management policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care and treatment.

PURPOSE
To promote consistency between utilization management reviewers by providing the criteria that determines the medical necessity.

BACKGROUND
Definitions
A. **Enteral nutritional therapy** delivers nutrient solution to the gastro-intestinal tract by nasogastric, jejunostomy, or gastrostomy tube via bolus, gravity or pump-controlled infusion. Enteral nutritional therapy is typically required for patients who have permanent non-function or disease of the structures that normally permit food to reach the small bowel or disease of the small bowel which impairs digestion and absorption of an oral diet. Enteral formulas may consist of semi-synthetic or natural ingredients.

B. **Sole source of nutrition**: Enteral nutrition feedings are intended to provide sufficient nutrients to maintain weight and strength appropriate to maintain the patient’s overall health status, and to achieve growth in children. Some patients are required, as a part of the physician-prescribed treatment plan, to ingest a small amount of oral feeding. However, the oral intake of these patients is not considered by their physician to be sufficient to maintain weight, or to maintain growth and development. Therefore, in such patients, the primary source of nutrition (the enteral feeding) is considered to be the sole source of nutrition.

BENEFIT CONSIDERATIONS
1. Prior authorization is required for enteral nutritional therapy. Please see the prior authorization list for prior authorization requirements.
2. Coverage may vary according to the terms of the member’s plan document.
   a. Most member plan documents exclude coverage of enteral feedings unless they are the sole source of nutrition.
3. Grocery products which are liquefied in a food blender to allow administration through an enteral system are not covered.
4. Digestive enzyme cartridges (e.g., Relizorb® [HCPCS code: B4105]) used in conjunction with enteral nutrition therapy is investigative and therefore not covered.
5. Refer to the member’s plan document for additional coverage information; e.g., coverage of medical dietary
treatment of phenylketonuria (PKU) or other metabolic disorders.

6. For Minnesota Health Care Programs (MHCP) members, criteria specified by the State of Minnesota must be met. Please refer to "Enteral Nutritional Products," of the chapter entitled "Nutritional Products and Related Supplies" in the MHCP provider manual for specific coverage information:

7. Enteral nutrition formulas that are administered orally and related supplies are not covered unless specifically included in the member’s plan document or addressed in a separate coverage policy. Amino acid-based elemental formulas are covered for specific diagnoses or disorders. Please refer to Coverage Policy: Amino Acid-Based Elemental Oral Formula or the member’s plan document for coverage indications.

8. Supplies and equipment necessary to accomplish enteral formula administration are covered according to the terms of the member plan document.

9. If the Medical Necessity Criteria and Benefit Considerations are met, Medica will authorize benefits within the limits in the member’s plan document.

10. If it appears that the Medical Necessity Criteria and Benefit Considerations are not met, the case will be reviewed by the medical director or an external reviewer. Practitioners are advised of the appeal process in their Medica Provider Administrative Manual.

MEDICAL NECESSITY CRITERIA

I. Indications for enteral feedings

   Enteral feedings (synthetic or semi-synthetic) are considered medically necessary when documentation in the medical record indicates that all of the following criteria are met:

   A. The enteral feedings must be the individual’s sole source of nutrition* (dietary adjustment or oral supplements are contraindicated or are not possible). Some patients are required, as a part of the physician-prescribed treatment plan, to ingest a small amount of oral feeding. However, the oral intake of these patients is not considered by their physician to be sufficient to achieve or maintain an acceptable body weight or to achieve growth in children. Therefore, in such patients, the primary source of nutrition (the enteral feeding) is considered to be the sole source.

   B. The patient has a functional intestinal tract, and has one of the following conditions:

      1. Non-function or disease of the pharynx, esophagus, or stomach that prevents nutrients from reaching the small intestine
      2. Central nervous system disease leading to sufficient interference with the neuromuscular coordination of chewing and swallowing such that a risk of aspiration exists.

   *Most member plan documents exclude coverage of enteral feedings unless they are the sole source of nutrition.

II. Enteral formula consisting of manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins, minerals and may include fiber, administered through an enteral feeding tube (HCPCS code: B4149), are eligible for coverage when the individual meets all of the following:

   A. Criteria for enteral nutritional therapy, in section I above
   B. Documentation indicating that patient has one of the following:

      1. Intolerance to a semi-synthetic enteral product
      2. Severe allergic reaction to a semi-synthetic enteral product.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

- For Medicare members, refer to the following, as applicable at: http://www.cms.hhs.gov/mcd/search.asp?

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Original Effective Date</th>
<th>May 2003</th>
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<tbody>
<tr>
<td>Administrative Update(s)</td>
<td>05/01/2017, 12/20/2017</td>
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References:

Pre-04/2016 MPC:

04/2016 MPC:
No new references.

04/2017 MPC:
No new references.

04/2018 MPC:
04/2019 MPC:
No new references.

04/2020 MPC: