Clinical Policy: Enteral Nutrition

Reference Number: TX.CP.MP.550
Last Review Date: 05/22

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Enteral nutritional products are those food products that are included in an enteral treatment protocol. They serve as a therapeutic agent for health maintenance and are required to treat an identified medical condition. Nutritional supplies and related equipment may also be a covered benefit.

This policy applies to the following products: STAR, STAR+PLUS, STAR Health, STAR Kids, and CHIP. For STAR+PLUS Dual and STAR+PLUS Dual Waiver members, services and/or adaptive aids/medical supplies are only a covered benefit after they have exhausted any third-party resources, including Medicare.

Policy/Criteria

It is the policy of Superior HealthPlan (SHP) that enteral nutrition products, supplies, and equipment are medically necessary when the following criteria under **sections I, II, or III** are met:

I. Members 21 Years of Age and Older:

A. Enteral Formula

1. Enteral nutrition and related supplies and equipment may be considered for prior authorization for members who are 21 years of age and older when all or part of the member's nutritional intake is received through a feeding tube; *and*
2. The enteral formula is the member's sole source of nutrition or primary source of nutrition.

- *Note: An enteral tube feeding is considered the primary source of nutrition when it comprises more than 70 percent of the caloric intake needed to maintain the member's weight. The percent of calories provided by an enteral formula may be calculated by dividing the member's daily calories supplied by the enteral formula by the daily caloric intake ordered by the physician to maintain the member's weight. The result is multiplied by 100 to determine the percentage of calories provided by the enteral formula.*

- *Note: Enteral formulas consisting of semi-synthetic intact protein or protein isolates (HCPCS codes B4150 and B4152) are appropriate for the majority of adult members who require enteral nutrition.*

II. Members Under 21 Years of Age:

A. Enteral Formula

1. Receive all or part of their nutritional intake through a tube; *or*

2. Have a metabolic disorder that requires specialized formula; *or*
3. For members who do not receive formula through a tube and do not have a metabolic disorder, the following documentation must be submitted and the request sent to a medical director for review:
   a. The underlying diagnosis or condition that results in the requirement for a nutritional product
   b. The member's overall health status
   c. Height and weight
   d. Why the member cannot be maintained on an age-appropriate diet
   e. Other formulas tried and why they did not meet the member's needs
   f. Total caloric intake prescribed by the physician

B. Nutritional Pudding Products
1. Documented oropharyngeal motor dysfunction; *and*
2. Receive greater than 50 percent of their daily caloric intake from a nutritional pudding product

C. Electrolyte Replacement Products
1. Underlying acute or chronic medical diagnosis or conditions that requires the replacement of fluid and electrolyte losses; *or*
2. Mild-to-moderate dehydration due to the persistent mild to moderate diarrhea or vomiting

- *Note: Electrolyte replacement products are **not** medically necessary for the following indications:*
  - Intractable vomiting,
  - Adynamic ileus,
  - Intestinal obstruction or perforated bowel,
  - Anuria, oliguria, or impaired homeostatic mechanism, or
  - Severe, continuing diarrhea, when intended for use as the sole therapy

III. Members of ALL Ages:

A. Food Thickener
Food thickener may be considered for members with a swallowing disorder

B. Nasogastric, Gastrostomy, or Jejunostomy Feeding Tubes
Additional feeding tubes requested over-the-allowable limit require prior authorization and are medically necessary if the submitted documentation supports medical necessity, such as infection at gastrostomy site, leakage, or occlusion. Over-the-allowable limit is as follows:
1. B4088 two (2) per rolling year
2. B9998 with modifier U2 two (2) per rolling year

C. Enteral Feeding Pumps
   1. Gravity or syringe feedings are not medically indicated, *or*
   2. The member requires an administration rate of less than 100 ml. per hr., *or*
   3. The member requires night-time feedings, *or*
   4. The member has one of the following conditions:
      a. Reflux and/or aspiration, *or*
      b. Severe diarrhea, *or*
      c. Dumping syndrome, *or*
      d. Blood glucose fluctuations, *or*
      e. Circulatory overload

D. Backpack/Carrying Case
   1. The member requires enteral feedings that last more than eight continuous hours, or feeding intervals that are less than the time that the member must be away from home to attend school or work, or to participate in extensive, physician-ordered outpatient therapies or to attend frequent, multiple medical appointments, *and*
   2. The member is ambulatory or uses a wheelchair that will not support the use of a portable pump by other means, such as an intravenous (IV) pole, *and*
   3. The portable enteral feeding pump is member-owned

      - *Note: Providers should utilize HCPCS code B9998 for the backpack/carrying case for a portable enteral feeing pump.*

E. Other Enteral Supplies
   1. Additional enteral feeding supply kits beyond the stated benefit limitation will be prior authorized on a case-by-case basis with documentation of medical necessity. The benefit limitation is as follows:
      a. B9998 with modifier U3 four (4) per month
      b. B4034 up to 31 per month
      c. B4035 up to 31 per month

   2. Related supplies and equipment for members who require nutritional products may be considered for prior authorization when medical necessity is documented for each item requested.

      Note: Gravity bags and pump nutritional containers are included in the feeding supply kits and will not be prior authorized separately.

F. Immobilized Lipase Cartridges
   1. Immobilized lipase cartridges will require prior authorization and may be considered with documentation of medical necessity indicating that the member meets all the following criteria:
      a. The member has exocrine pancreatic insufficiency.
      b. The member utilizes an enteral feeding pump.

c. Member is age five or older.

2. The benefit limitation is as follows:
   a. B4105 up to 62 per month

Note: *One cartridge can be used with up to 500mL of formula, with a maximum of two cartridges used per day.*

IV. The following enteral nutrition supplies are **non-covered services**:

A. Medicaid:
1. Nutritional products traditionally used for infant feeding
2. Nutritional products for the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth. The underlying medical etiology of these conditions must be documented
3. Nutritional bars
4. Nutritional products for members who could be sustained on an age-appropriate diet

B. CHIP:
1. Nutritional products traditionally used for infant feeding
2. Nutritional products for the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth. The underlying medical etiology of these conditions must be documented
3. Nutritional products for members who could be sustained on an age-appropriate diet.
4. Nutritional products in pudding form (except for members with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product)
5. Nutritional products except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
N/A	

HCPCS Codes	Description
B4034	Enteral feeding supply kit; syringe fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape
B4035	Enteral feeding supply kit; pump fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape
B4088	Gastrostomy/jejunostomy tube, low-profile, any material, any type, each
B4150	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4152	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B9998	NOC for enteral supplies
B4036	Enteral feeding supply kit; gravity fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape
B4081	Nasogastric tubing with stylet
B4082	Nasogastric tubing without stylet
B4083	Stomach tube - Levine type
B4087	Gastrostomy/jejunostomy tube, standard, any material, any type, each
B4100	Food thickener, administered orally, per oz
B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit
B4104	Additive for enteral formula (e.g., fiber)
B4105	In-line cartridge containing digestive enzyme(s) for enteral feeding, each
B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4153	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4154	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4155	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arginine), fat (e.g., medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit
B4157	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and

HCPCS Codes	Description
	minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4158	Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit
B4159	Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit
B4160	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes
B4161	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4162	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B9000	Enteral nutrition infusion pump - without alarm
B9002	Enteral nutrition infusion pump, any type

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
Updated Purpose and included statement regarding Star Plus Waiver and Star Plus Dual Waiver; updated policy by adding general and specific criteria, adding statement that all enteral nutrition product, supplies and equipment requires prior authorization, updated Medicaid allowable table, added repair and replacement criteria; updated authorization protocol and work process; attached ARQ DME list with benefit limitations; updated references. Updated signatories.	03/14	03/14
Removed work process and imbedded in attachment section. Added policy to reference list.	02/15	02/15
Removed age requirement for enteral nutrition. Defined what is considered primary source of nutrition. Added specifications on pediatric formula requirement for members under 21. Protocol Physician signature requirement to include name. Removed attached ARQ Spreadsheet. Updated references.	03/15	03/15

Reviews, Revisions, and Approvals	Date	Approval Date
Regulatory updates. Removed work process attachment. Updated signatories.	03/16	03/16
STAR Kids added to products.	08/16	08/16
Removed B9000 and added B9998 with modifier U4 (2 per rolling year). Grammatical edits. Updated references.	03/17	03/17
Significant rewrite of policy. Prior authorization criteria updated to align with Texas Medicaid criteria.	06/17	06/17
Annual Review. Updated references and signatories. Deleted revision history prior to 2014	07/18	07/18
Updated to new template from TX.UM.10.50 (TX.CP.MP.550 nomenclature implementation 09/14/19). Updated references. Removed prior authorization work process information regarding six month authorization period and supporting documentation for recertification.	07/19	07/19
Added notes regarding PA after allowable limit for feeding tubes and other enteral supplies, with corresponding codes.	12/19	12/19
Annual review. In section IV created A and B to clarify Medicaid and CHIP non-covered services. Updated references.	10/20	10/20
Clarified language in section I. Members 21 Years of Age and Older A. Enteral formula.	03/21	03/21
In section III added F criteria for Immobilized Lipase Cartridges. Added procedure code B4105 to the HCPCS chart. Updated references.	05/21	05/21
Annual review. Updated references. In section 3 F, removed criteria point regarding compatible formula and amount given and replaced with *"Member is age five or older".*	05/22	05/22

References

1. American Academy of Pediatrics Committee on Nutrition. Reimbursement for medical foods for inborn errors of metabolism. Pediatrics. 1994; 93(5):860.
2. ASPEN. American Society for Parenteral and Enteral Nutrition Board of Directors. Standards of Practice for Home Nutrition Support. Journal of Parenteral and Enteral Nutrition, Volume 33, Number 2, March/April 2009 122-167. Available at http://pen.sagepub.com. Accessed June 3, 2013.
3. Cabre Gelada E. Enteral nutrition in gastrointestinal disease. Gastroenterol Hepatol. 1998; 21(5):245-256.
4. DeWitt RC, Kudsk KA. Enteral nutrition. Gastroenterol Clin North Am. 1998; 27(2):371-386.
5. Forchielli M, Bines J. Enteral Nutrition 68, 766-775. Abbot Nutrition Health Institute. Available at http://anhi.org/learning/pdfs/bcdecker/Enteral_Nutrition.pdf. Accessed June 3, 2013.
6. Howard L, Patton L, Dahl RS. Outcome of long-term enteral feeding. Gastrointest Endosc Clin N Am. 1998; 8(3):705-722.

7. Kirkland, Rebecca MD, MPH and Motil, Kathleen, MD, PhD. Etiology and evaluation of failure to thrive (undernutrition) in children younger than two years. UpToDate. July 2013. Available at http://www.uptodate.com/contents/etiology-and-evaluation-of-failure-to-thrive-undernutrition-in-children-younger-than-two-years#H12. Accessed August 13, 2013.
8. Scrimshaw NS, Murray EB. The acceptability of milk and milk products in populations with a high prevalence of lactose intolerance. Am J Clin Nutr. 1988; 48(4 Suppl):1079-1159.
9. Texas Medicaid Provider Manual, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook, 2.2.18 Nutritional (Enteral) Products, Supplies, and Equipment, April 2022.
10. TX.UM.26 Electronic and Verbal Signature Policy
11. Uniformed Managed Care Contract

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise

professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.