Enteral Nutrition and Pumps

State(s):	LOB(s):
☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*	☒ *Commercial* ☒ *Medicare* ☒ *Medicaid*

Enterprise Policy

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determination are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Specialized nutritional support is often required for patients who have chronic disease or for those undergoing long-term rehabilitation who are at risk for malnutrition. Nutritional support can be provided orally, enterally and intravenously. For the purpose of this policy enteral nutritional support is defined as nutritional support administered through a feeding tube (e.g. nasogastric, jejunostomy, PEG tube, etc.).

Enteral nutrition and medical foods **do not** accumulate to the DME calendar/benefit year maximum. Enteral feeding supply kits **do** accumulate to the calendar/benefit year DME maximum.

This policy does **not** cover Total Parenteral Nutrition (TPN). Please see the policy "Total Parenteral Nutrition (TPN) in the Home Setting" for guidance on TPN.

Criteria

Commercial

Prior authorization is required.

I. **Inborn Errors of Metabolism:** a group of rare disorders that are caused by an inherited genetic defect and alter the body's ability to derive energy from nutrients.

Coverage criteria: clinical documentation must meet **ALL** of the following:

- Diagnosis of one of the following:
  - Inborn Error of Metabolism (e.g., Maple syrup urine disease type Ib and II, Phenylketonuria (PKU), Homocystinuria, Tyrosinemia types I, II and III, Glutaric aciduria/glutaric academia type I and

II,Methylmalonic academia, Glycogen storage disease, Organic acid metabolism disorders); and

- A physician has issued a written order for the enteral nutrition and documents the impairment is expected to exceed 90 days.
- **Oral nutrition support**: nutritional support administered orally is only covered when all other criteria above are met the following applies:
    - Member has an inborn error of metabolism diagnosis and oral nutrition support is medical necessary for the specific condition.

Initial authorization approval period: 6 months unless otherwise specified.

Reauthorization approval period: 12 months unless otherwise specified.

See Policy Exclusion section for items not covered for any condition or indication.

II. Severe Intestinal Malabsorption: the disordered or inadequate absorption of nutrients from the intestinal tract, especially the small intestine.

Coverage criteria: clinical documentation must meet **ALL** of the following:

- Diagnosis of one of the following:
    - Severe Intestinal Malabsorption due to one of the following: cholestatic liver disease, Crohn's disease, eosinophilic gastrointestinal disorders, lymphangiectasia, parenchymal liver disease, post-gastrectomy malabsorption and post-intestinal resection malabsorption radiation enteritis, short-bowel syndrome, tropical sprue, ulcerative colitis (when there are documented objective signs and symptoms of malabsorption such as serum albumin levels), Whipple's disease; and
- A physician has issued a written order for the enteral nutrition and documents the impairment is expected to exceed 90 days; and
- The enteral nutrition comprises the sole source, or an essential and predominant source, of nutrition (i.e., 60% or more of required caloric nutritional intake); and
- Nutritional support must be administered through a feeding tube only (e.g., nasogastric, jejunostomy, peg, tube). Enteral nutrition products and related supplies that are administered orally (i.e., by mouth) are not coverable.
- **Oral nutrition support**: nutritional support administered orally is only covered when all other criteria above are met the following applies:
    - Member is on a **WASHINGTON plan.**

Initial authorization approval period: 6 months unless otherwise specified.

Reauthorization approval period: 12 months unless otherwise specified.

See Policy Exclusion section for items not covered for any condition or indication.

III. **Anatomic Abnormalities or Motility Disorders:** an anatomic abnormality (e.g. obstruction due to head and neck cancer or reconstructive surgery, etc.) or a motility disorder (e.g., severe dysphagia following a stroke, cerebral palsy, neuromuscular, CNS disease) interfering with the ability to adequately chew or swallow increasing the risk of malnutrition.

Coverage Criteria: clinical documentation must meet **ALL** of the following:

- A physician has issued a written order for the enteral nutrition and documents the impairment is expected to exceed 90 days; and
- The enteral nutrition comprises the sole source, or an essential and predominant source, of nutrition (i.e., 60% or more of required caloric nutritional intake); and
- Nutritional support must be administered through a feeding tube only (e.g., nasogastric, jejunostomy, peg, tube). Enteral nutrition products and related supplies that are administered orally (i.e., by mouth) are not coverable.

Initial authorization approval period: 6 months unless otherwise specified.

Reauthorization approval period: 12 months unless otherwise specified.

IV. **Failure to Thrive: results from multi-factorial situation with result of undernourishment and related sequela:**

Coverage Criteria: clinical documentation must meet **ALL** of the following:

- A physician has issued a written order for the enteral nutrition and documents the impairment is expected to exceed 90 days; and
- The enteral nutrition comprises the sole source, or an essential and predominant source, of nutrition (i.e., 60% or more of required caloric nutritional intake); and
- Nutritional support must be administered through a feeding tube only (e.g., nasogastric, jejunostomy, peg, tube). Enteral nutrition products and related supplies that are administered orally (i.e., by mouth) are not coverable.

Initial authorization approval period: 6 months unless otherwise specified.

Reauthorization approval period: 12 months unless otherwise specified.

V. **Behavioral Health Eating Disorders:** Enteral feeding may be medically necessary for treatment of patients with severe/refractory eating disorders unable to maintain an ideal body weight through oral feeding despite participating in an intensive eating disorder treatment program

****Behavioral Health Medical Director review is required for **ALL** requests***

Coverage Criteria: the following must be met:

- Behavioral Health Medical Director approves the request and determines the authorization time period per current treatment plan; and
- Member is currently participating in a comprehensive eating disorder treatment program; and
- Nutritional support must be administered through a feeding tube only (e.g., nasogastric, jejunostomy, peg, tube). Enteral nutrition products and related supplies that are administered orally (i.e., by mouth) are not coverable.

VI. Enteral Infusion Pumps: Enteral feedings are delivered by syringe, gravity, or via an electric infusion pump. Feedings can be delivered on an intermittent or continuous basis.

Coverage Criteria for an enteral infusion Pump: ONE of the following criteria must be met:

- The individual has severe diarrhea, dumping syndrome, fluctuating blood glucose levels, or a condition that results in circulatory overload: or
- The individual's medical condition is such that gravity or syringe feeding is not clinically appropriate (e.g., there is a risk of aspiration or reflux): or
- The individual's medical condition requires that the nutritional formula administration rate is such that a pump is required to titrate infusion for patient safety (e.g., less than 100 cc per hour).

NOTES: Supplies for gravity feedings do not require preauthorization if under $1000.
Feeding tube supplies for medications and maintenance only do not require preauthorization if under $1,000. Supplies over $1,000 are coverable with a physician's order.

Policy Exclusions

PacificSource does not cover ANY of the following items for any condition or indication:

- Normal grocery items.
- Food thickeners.
- Dietary and food supplements.
- Lactose-free products; products to aid in lactose digestion.
- Gluten-free food products.
- Weight-loss foods and formula; products to aid weight loss.
- Low carbohydrate diets.
- Baby food.
- Banked breast milk breast milk supplements and fortifiers; **note** Billings Clinic covers banked breast milk (e.g., Prolacta) when billed with room and board charge (not separately reimbursable).
- Grocery items that can be blenderized and used with an enteral feeding system.
- Nutritional supplement puddings.

- High protein powders and mixes.
- Oral vitamins and minerals.

Medicaid

PacificSource Community Solutions Physical Health follows Oregon Health Plan (OHP) per Oregon Administrative Rules (OAR) 410-140-0000 to 0320 for coverage of Enteral Nutrition and Pumps.

PacificSource Medicaid Pharmacy reviews CPT codes B4150 thru B4161.

HCPCS code B4149 Blenderized Foods is not a covered benefit under the OHP.

Medicare

PacificSource Medicare uses Local Coverage Determination L33783 for Enteral Nutrition and National Coverage Determination 180.2 for Enteral Nutritional Therapy.

Experimental/Investigational/Unproven

Digestive enzyme cartridge that connects in-line with existing enteral feeding pump tubing sets and patient extension sets or enteral feeding tubes are considered experimental/ investigational and not covered.

Definitions

Medical food - Foods that are formulated to be consumed or administered enterally under the supervision of a physician, that are specifically formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts, that are for the medical and nutritional management of patients with [metabolic disorders] and that are essential to optimize growth, health and metabolic homeostasis.

Coding Information

This following list of codes are for informational 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.

HCPCS #	Description	Type of Expense	Comments
B4149, B4154, B4157, B4162, S9434, S9435	Metabolic Food	DME/Supply TOS 3618*	PA required.
B4150, B4152, B4153, B4155, B4158, B4159, B4160, B4161,	Enteral Formula	DME/Supply TOS 6386*	Prior authorization required.
B4034, B4035, B4036	Enteral Feeding supply kit;	DME/Supply TOS 6386*	Prior authorization required

B4105	In-line cartridge containing digestive enzyme(s) for enteral feeding	DME/Supply	Not covered
S9342	Home therapy; Enteral nutrition via pump	DME/Supply	Prior authorization not required

- TOS 6318 = DME with no maximum (no PA requirement)
- TOS 6386 =DME enteral supplies and formula

Related Policies

Total Parenteral Nutrition (TPN) in the Home Setting

References

Boullata JI et al Optimizing Clinical and Cost Outcomes for Patients on Enteral Nutrition Support for Treatment of Exocrine Pancreatic Insufficiency: Proceedings from an Expert Advisory Board Meeting, Popul Health Manag 2019 Jun 1
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6537119/

Center for Medicare and Medicaid Services (CMS), National Coverage Determination (NCD) for Enteral and Parenteral Nutritional THERAPY (180.2).

Katkin JP et al, Cystic fibrosis: Assessment and management of pancreatic insufficiency. UpToDate Sep 03, 2020. https://www.uptodate.com/contents/cystic-fibrosis-assessment-and-management-of-pancreatic-insufficiency?search=pancreatic%20enzymes&source=search_result&selectedTitle=6~150&usage_type=default&display_rank=5

Appendix

Policy Number: [Policy Number]

Effective: 10/1/2020 **Next review:** 2/1/2022

Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s): ORS 743A.188, MTS 33-22-131