

Clinical Policy: Enteral and Oral Nutrition Supplements

Reference Number: LA.CP.MP.500

Last Review Date: 10/19

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Enteral Nutrition (EN) aids in the preservation of the gastrointestinal tract by direct absorption of enteral nutrients into the small intestine. It is easier and safer to administer than parenteral nutrition due to absence of an intravenous access. The short-term methods (< 3 months) are best administered by a percutaneous gastrostomy or jejunostomy tube.

Oral nutritional supplements can be used to meet nutritional requirements when there is a functional gastrointestinal tract and swallowing mechanism.

Policy/Criteria

- I. It is the policy of Louisiana HealthCare Connections that enteral nutritional supplements are **medically necessary** for adults and children when meeting, both of the following (A-B):
 - A. Documented presence of an enteral tube;
 - B. Requirement for enteral feeding as the primary source of nutrition ($\geq 70\%$ caloric need).
- II. It is the policy of Louisiana HealthCare Connections that enteral nutritional therapy for temporary impairments or for convenience feeding via gastrostomy is considered **not medically necessary**.
- III. It is the policy of Louisiana HealthCare Connections that oral nutritional supplements are **medically necessary** when meeting one of the following (A - B),
 - A. Requested for poor weight gain/failure to thrive for members < 2 years old with all of the following (1-4):
 1. Has an underlying disease process and body mass index (BMI) or height < 5th percentile for their age (must include growth charts);
 2. Has not been diagnosed with a medical condition such as dwarfism or other syndrome normally associated with low body mass;
 3. Has demonstrated inadequate response to regular foods or formulas;
 4. Has tried and failed readily available high calorie foods such as Carnation Instant Breakfast or other age appropriate choices;
 - B. Requested for a condition other than poor weight gain/failure to thrive, one of the following (1-3):
 1. Nutritional pudding products for documented oropharyngeal motor dysfunction, regardless of age;
 2. Electrolyte replacement products (e.g. Pedialyte or Oralyte), both of the following (a-b):
 - a. Any of the following indications (i-ii):
 - i. Age < 21, with underlying acute or chronic medical diagnosis or conditions that indicate the need to replace fluid and electrolyte losses;

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- ii. Mild to moderate dehydration due to persistent mild to moderate diarrhea or vomiting;
- b. None of the following conditions (i-v):
 - i. Intractable vomiting;
 - ii. Adynamic ileus;
 - iii. Intestinal obstruction or perforated bowel;
 - iv. Anuria, oliguria or impaired homeostatic mechanism;
 - v. Severe, continuing diarrhea when electrolyte replacements are intended for use as the sole therapy;
- 3. Oral nutrition other than nutritional pudding products or electrolyte replacement, both of the following (a-b):
 - a. Underlying condition, any of the following (i-vii):
 - i. Inability to ingest adequate nutrition orally, any of the following (a-j):
 - a) Disorders of sucking and swallowing (e.g. jaw fracture, mechanical disorders, craniofacial disorder, cleft lip, etc.);
 - b) Neurological or neuromuscular disorders (e.g. Cerebral Palsy, dysphagia, ALS, Parkinson's, etc.);
 - c) Prematurity (excludes standard formulas that do not require prescription for WIC);
 - d) Congenital abnormalities of the upper GI tract or airways (e.g. tracheoesophageal fistula, esophageal atresia, etc.);
 - e) Tumors (e.g. oral, head or neck cancer, etc.);
 - f) Trauma;
 - g) Critical illness (e.g. mechanical ventilation);
 - h) GERD with weight loss;
 - i) CVA with dysphasia, dysphagia or aspiration diagnosis;
 - j) Chronic renal failure or end stage renal disease with a recent albumin level documented;
 - ii. Disorders of digestion and malabsorption, any of the following (a-o):
 - a) Cystic fibrosis;
 - b) Pancreatic insufficiency;
 - c) Short-bowel syndrome;
 - d) Inflammatory bowel disease (e.g. ulcerative colitis, Crohn's, etc.);
 - e) Celiac disease;
 - f) Congenital abnormalities of the GI tract (e.g. microvillus inclusion, tufting enteropathy, etc.);
 - g) Chronic enteritis of 3 weeks or more;
 - h) Intractable diarrhea in infancy;
 - i) Auto-immune enteropathy immunodeficiency (e.g. HIV/AIDS, severe combined immunodeficiency, etc.);
 - j) Post gastrointestinal surgery;
 - k) Graft-versus host disease;
 - l) Solid organ transplant;
 - m) Intestinal fistula;
 - n) Hepatobiliary disease (biliary atresia, alagille syndrome, etc.);
 - o) Inborn errors of metabolism;

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- iii. Disorders of gastrointestinal motility or chronic pseudo-obstruction (e.g. gastroparesis);
- iv. Acute or chronic pancreatitis;
- v. Administration of disease treatment, any of the following (a-c):
 - a) Ketogenic diet in epilepsy;
 - b) Administration of pharmaceutical agents (chemotherapy, chronic renal failure or long term antibiotic use. This doesn't include ADHD medication for those capable of taking oral feeds);
 - c) Bowel washouts in severe chronic constipation;
- vi. Behavioral disorders affecting eating (anorexia, bulimia, severe depression);
- vii. Food allergy, any of the following (a-b):
 - a) Food protein-induced enterocolitis and enteropathy;
 - b) Allergic eosinophilic gastroenteritis (requires supported history/physical findings and laboratory testing);
- b. One of the following specified age groups (i-iii):
 - i. Age > 21 years and any of the following (a-c):
 - a) BMI < 18.5 kg/m²;
 - b) BMI < 20 kg/m² and unintentional weight loss > 5% within past 3-6 months;
 - c) Unintentional weight loss > 10% within past 3-6 months;
 - ii. Age > 1 year and ≤ 21 years and any of the following (a-b):
 - a) Nutritional needs are not met through diet due to a medical condition, as shown on growth chart by a trend in weight loss, poor weight gain, or poor growth;
 - b) Inadequate oral intake or expected inadequate oral intake over a period of 3-5 days;
 - iii. Age < 1 year and any of the following (a-c):
 - a) Specialized formula is predominant source of nutritional intake (>70%);
 - b) Inadequate oral intake or expected inadequate oral intake over a period of 1-3 days;
 - c) Commercial formulas including soy based products have been tried and failed or are contraindicated.

Coding Implications

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CPT® Codes	Description
N/A	

HCPCS Codes	Description
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit
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)
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
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
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 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 proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
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

HCPCS Codes	Description
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

Reviews, Revisions, and Approvals	Date	Approval Date
Criteria annual review in LA.UM.10.50	05/19	05/19
Clinical policy created from medical necessity criteria removed from LA.UM.10.50. Policy restructured and reworded for clarity.	06/19	
Formatting changes only	08/19	
Added supportive oncology 2011 reference Added to Administration of pharmaceutical agents: chemotherapy, chronic renal failure or long term antibiotic use and that it doesn't include ADHD meds	10/19	

References

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9. Texas Medicaid Healthcare Partnership (TMHP). 2.4.11 Nutritional Products. Texas Medicaid Providers Procedures Manual Vol 1&2. May 2013. Available at http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/TMPPM/2013/Mary2013TMPPM.pdf Accessed June 3, 2012.

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10. Louisiana Medicaid Program Ch18.Durable Medical Equipment Section 18.2, Specific Coverage pg. 47
11. Louisiana Medicaid Program DME Provider Manuel Section 18.2 page 43-44/66.
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13. Drs. Davis, Feyer, Ortner and Zimmermann. Supportive Oncology 2011 pages 635-655.

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.

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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.

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