

# Clinical Policy: Enteral Nutrition

Reference Number: LA.CP.MP.500c

Date of Last Revision: 04/25

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## 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.

## Policy / Criteria

### I. Medically Necessary Enteral Nutritional Supplements

It is the policy of Louisiana HealthCare Connections that enteral nutritional supplements are medically necessary for adult and children member/enrollees when **meeting all of the following**:

A. Medical documentation, such as hospital records and clinical findings, support an independent conclusion the beneficiary has a **permanently inoperative internal body organ or function** which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the beneficiary's general condition.

- For purposes of this policy, **permanent** means an **indefinite period of more than one month**.

B. Enteral feeding must be for an average of **at least 750 calories per day** over the prescribed period and must constitute **at least 70 percent of the daily caloric intake**.

- Coverage of prescribed feedings of less than an average of 750 calories per day may only be considered with additional physician documentation and justification of the reason for prescribing less than an average of 750 calories per day.

C. All requests must include the following information:

1. Name of the nutrient product or nutrient category;
2. The physician(s) must document the reason for prescribing a formula including beneficiary's diagnoses;
3. Number of calories prescribed by enteral feeding per day (100 calories equals one unit) and whether the prescribed amount constitutes 70 percent or more of the daily caloric intake;
4. Frequency of administration per day;

5. Route of administration, if tube fed (i.e., nasogastric, jejunostomy, gastrostomy, percutaneous enteral gastrostomy, or naso-intestinal tube); and
6. Reason for use of a pump, if prescribed.

## **II. Medically Necessary Enteral Formulas – Inborn Errors of Metabolism**

It is the policy of Louisiana HealthCare Connections that enteral formulas are medically necessary for members/enrollees of all ages when:

**A.** Member/enrollee has known or suspected **inborn errors of metabolism** and is served by the **Office of Public Health (OPH) Genetic Disease Program**.

**B.** The member/enrollee is suspected of having an inborn error of metabolism, **pending the results of a definitive evaluation**, when such enteral formula is needed to prevent morbidity.

- In this case, the enteral formula does not need to be ordered by a specialist.

**C.** Documentation of medical necessity.

- The Genetic Disease Program must maintain a completed **Request for Enteral Formula for Inborn Errors of Metabolism** order form in the member/enrollee's record, which is **signed and dated by the appropriate ordering provider**.

## **III. Cost-Effective Nutritional Support**

It is the policy of Louisiana HealthCare Connections that enteral feedings can only be provided for the **most economic package equivalent** in calories and ingredient content to the needs of the beneficiary as established by medical documentation.

- The physician(s) must document the reason for prescribing a formula including beneficiary's diagnoses.

Approved requests shall be reviewed at periodic intervals **not to exceed six months**.

- Approval may be granted for up to **six months at a time**.
- Medicaid, however, will pay for **no more than one month's supply** of enteral nutrients at any one time.

## **IV. Enteral Infusion Pumps**

It is the policy of Louisiana HealthCare Connections that a **standard enteral infusion pump** will be approved only with **documented evidence the pump is medically necessary**, and that **syringe or gravity feedings are not satisfactory** due to complications such as aspiration, diarrhea, dumping syndrome, etc.

A. Louisiana Healthcare Connections will pay for the **rental** of a standard enteral infusion pump and accessories.

- LHCC can pay for **repairs not covered by the warranty or lease agreement**.

#### **V. Not Medically Necessary - Temporary or Convenience Feeding**

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**.

#### **VI. Not Medically Necessary - Grocery and Baby Foods**

It is the policy of Louisiana HealthCare Connections that **baby food and other regular grocery products** that can be used with an enteral system are considered **not medically necessary**.

#### **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 2024, 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 and may not support medical necessity. 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.

NOTE: Coverage is subject to each requested code's inclusion on the corresponding LDH fee schedule. Non-covered codes are denoted (\*) and are reviewed for Medical Necessity for members under 21 years of age on a per case basis.

<b>CPT® Codes</b>	<b>Description</b>
N/A	

<b>HCPCS Codes</b>	<b>Description</b>
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
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

HCPCS Codes	Description
B4082	Nasogastric tubing without stylet
B4083	Stomach tube - Levine type
B4088	Gastrostomy/jejunostomy tube, low-profile, any material, any type, each
B4100	Food thickener, administered orally, per oz
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,

HCPSC Codes	Description
	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
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
B9002	Enteral nutrition infusion pump, any type
B9998	NOC for enteral supplies
E0776	Portable IV pole with adjustable stand to hang bags of fluids or medications

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective 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		
Added what is not covered for enteral feedings Added review time frame for enteral feedings Added caloric criteria for enteral feedings Added LDH Reference	04/21		
Changed name of policy from Enteral and Oral Nutrition Supplements to Enteral Nutrition. Changed revision date in header to read Date of Last Revision. Updated description to match LDH description. Combined the 750 calorie day prescription with I.B. and added language from LDH provider manual. Added section to include the information that is required in all requests. Removed sections on oral nutrition. Added HCPCS codes that are included on the DME listed fee service: B4034, B4035, B4036, B4081, B4082, B4083, B4088, B4100, B9002, B9998, E0776. Changed Date in revision log to say Revision Date.	1/23	4/10/23	
Annual Review. Updated References. Removed "Documented presence of enteral tube" from section I. Updated Criteria in section I. Updated information and criteria in description.	11/23	1/23/24	2/22/24
Annual Review. Format changes without changes to criteria. References reviewed and updated.	4/25	6/24/25	7/24/25

## **References**

1. Louisiana Medicaid Program DME Provider Manual. Chapter 18.2 Specific coverage criteria. 18.2.11. Issued:07/16/24. Replaced 02/28/23.

## **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. LHCC 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.

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