Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

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Joint Medical Policies are a source for BCBSM and BCN medical policy information only. These documents are not to be used to determine benefits or reimbursement. Please reference the appropriate certificate or contract for benefit information. This policy may be updated and is therefore subject to change.

***Current Policy Effective Date: 5/1/21**
(See policy history boxes for previous effective dates)

Title: Enteral Nutrition

Description/Background

Nutritional support is essential for patients who are unable to meet their daily caloric or fluid requirements orally. Enteral delivery (directly into the stomach or intestine) is the preferred delivery method as it is most similar to the normal physiologic method of nutrient delivery. Cost is less with enteral delivery than with parenteral (intravenous) nutritional support and there are fewer complications.

Enteral nutrition is provided by inserting a tube directly into the stomach or small intestine for delivery of the required dietary supplements. The nutritional formula can be delivered by gravity or by pump. Feeding may be either intermittent or continuous throughout the day and/or night. Enteral nutrition may range from supplementing a patient's oral intake to supplying all of the patient's daily nutrition. Special formulas are available to meet different nutritional needs. Enteral nutrition may be provided safely and effectively in the home by a nonprofessional person or family member who has received specialized training.

Enteral nutrition is an option when a patient is unable to maintain a caloric intake sufficient to maintain weight and overall health.

Regulatory Status:

According to the U.S. Food and Drug Administration, "the term medical food, as defined in section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is 'a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive

nutritional requirements, based on recognized scientific principles, are established by medical evaluation.'"
"Medical foods do not have to undergo premarket review or approval by FDA and individual medical food products do not have to be registered with FDA".

Medical Policy Statement

The safety and effectiveness of enteral nutrition for patients who meet the patient selection criteria have been established. It is a useful therapeutic option when indicated.

Inclusionary and Exclusionary Guidelines (Clinically based guidelines that may support individual consideration and pre-authorization decisions)

The patient must have an impairment that is long-term or "permanent". Coverage is possible for patients with partial impairments, eg, a patient with dysphagia who can swallow small amounts of food or a patient with Crohn's disease who requires prolonged infusion of enteral nutrients to overcome problems with absorption.

Note: Permanence does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If the physician substantiates that a condition is of long and indefinite duration (ordinarily at least three months) the test of permanence may be met.

The medical record must document all information relevant to: a) the patient requiring the nutrition and b) the nutritional prescription.

Inclusions:
Enteral nutrition is established for patients who require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status due to the following conditions:

- A dysfunction of indefinite duration or disease of the structures that normally permit food to reach the small bowel, or
- A disease of the small bowel that impairs digestion and absorption of an oral diet

Note: When a feeding pump is requested, it must be supported by sufficient medical documentation to establish that the pump is medically necessary (eg, gravity feeding is not satisfactory due to aspiration, diarrhea, dumping syndrome, etc.). Allowance is made for the simplest model that meets the medical needs of the patient as established by medical documentation.

Exclusions:

- Patients with a functioning gastrointestinal tract whose need for enteral nutrition is due to reasons such as anorexia or nausea associated with mood disorder, end-stage disease, etc.
- Patients in whom adequate nutrition is possible by dietary adjustment and/or oral supplements

- Enteral nutrition products that are administered orally and related supplies
- Food thickeners, baby food, infant formulas and other regular grocery products are not covered in conjunction with oral or enteral feedings and related supplies

Note: For patients with inborn errors of metabolism who require specialized medical formula, please refer to the policy “Medical Formula for Inborn Errors of Metabolism”.

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure)*

Established codes:

B4034	B4035	B4036	B4081	B4082	B4083
B4087	B4088	B4102	B4103	B4104	B4149
B4150	B4152	B4153	B4154	B4155	B4157
B4158	B4159	B4160	B4161	B4162	B9002
B9998					

Other codes (investigational, not medically necessary, etc.):

B4100

Rationale

The development of techniques to secure a patient’s nutrition has increased the survival of severely ill patients. Feeding by the enteral route is more physiologic than the intravenous route, and therefore has fewer short- and long-term complications. The use of the gastrointestinal tract results in superior fluid homeostasis and the function of the intestinal is better preserved. In these conditions, tube feedings provide sufficient nutrients to maintain weight and strength commensurate with the patient’s overall health status.

Government Regulations
National:

National Coverage Determination (NCD) for Enteral and Parenteral Nutritional Therapy (180.2), Effective Date of this Version 7/11/1984

Benefit Category
Prosthetic Devices
Please Note: This may not be an exhaustive list of all applicable Medicare benefit categories for this item or service.

Indications and Limitations of Coverage
There are patients who, because of chronic illness or trauma, cannot be sustained through oral feeding. These people must rely on either enteral or parenteral nutritional therapy, depending upon the particular nature of their medical condition.

Coverage of nutritional therapy as a Part B benefit is provided under the prosthetic device benefit provision which requires that the patient must have a permanently inoperative internal body organ or function thereof. Therefore, enteral and parenteral nutritional therapy are not covered under Part B in situations involving temporary impairments. Coverage of such therapy, however, does not require a medical judgment that the impairment giving rise to the therapy will persist throughout the patient's remaining years. If the medical record, including the judgment of the attending physician, indicates that the impairment will be of long and indefinite duration, the test of permanence is considered met.

If the coverage requirements for enteral or parenteral nutritional therapy are met under the prosthetic device benefit provision, related supplies, equipment and nutrients are also covered under the conditions in the following paragraphs and the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §120.

Enteral Nutrition Therapy
Enteral nutrition is considered reasonable and necessary for a patient with a functioning gastrointestinal tract who, due to pathology to, or nonfunction of, the structures that normally permit food to reach the digestive tract, cannot maintain weight and strength commensurate with his or her general condition. Enteral therapy may be given by nasogastric, jejunostomy, or gastrostomy tubes and can be provided safely and effectively in the home by nonprofessional persons who have undergone special training. However, such persons cannot be paid for their services, nor is payment available for any services furnished by nonphysician professionals except as services furnished incident to a physician's service.

Typical examples of conditions that qualify for coverage are head and neck cancer with reconstructive surgery and central nervous system disease leading to interference with the neuromuscular mechanisms of ingestion of such severity that the beneficiary cannot be maintained with oral feeding. However, claims for Part B coverage of enteral nutrition therapy for these and any other conditions must be approved on an individual, case-by-case basis. Each claim must contain a physician's written order or prescription and sufficient medical documentation (e.g., hospital records, clinical findings from the attending physician) to permit an independent conclusion that the patient's condition meets the requirements of the prosthetic device benefit and that enteral nutrition therapy is medically necessary. Allowed claims are to be reviewed at periodic intervals of no more than 3 months by the contractor's medical consultant or specially trained staff, and additional medical documentation considered necessary is to be obtained as part of this review.

Medicare pays for no more than one month's supply of enteral nutrients at any one time.
If the claim involves a pump, it must be supported by sufficient medical documentation to establish that the pump is medically necessary, i.e., gravity feeding is not satisfactory due to aspiration, diarrhea, dumping syndrome. Program payment for the pump is based on the

reasonable charge for the simplest model that meets the medical needs of the patient as established by medical documentation.

Local:

CGS Administrators, LLC
Local Coverage Determination (LCD): Enteral Nutrition (L33783)
Original Effective Date 10/01/2015, Revision Effective Date 01/01/2020
Retirement Date: 11/12/2020

CGS Administrators, LLC
Enteral Nutrition - Policy Article (A52493)
Effective 10/01/2015, Revision Effective Date 04/30/2020
Retirement Date: 11/12/2020

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

Medical Formula for Inborn Errors of Metabolism
Nutritional Counseling - BCN only
Total Parenteral Nutrition (Hyperalimentation)

References

1. Blue Cross Blue Shield Association, "Total Parenteral Nutrition and Enteral Nutrition in the Home," *Medical Policy Reference Manual*, # 1.02.01, Issue 1:2003, original policy date 7/31/96, last review date 12/14/05, Archived June 2009.
2. Centers for Medicare & Medicaid Services (CMS), Medicare Coverage Database, "NCD for Enteral and Parenteral Nutritional Therapy," Manual Section Number 180.2, original effective date 7/11/1984.
3. CGS Administrators, LLC, "LCD for Enteral Nutrition," L33783, Effective date 10/01/2015, Revision Effective Date 01/01/2020, Retirement Date 11/12/2020.
4. CGS Administrators, LLC, "Article for Enteral Nutrition," (A52493), Policy Article, Original Effective Date 10/1/15, Revision Effective Date 04/30/2020, Retirement Date 11/12/2020.
5. Shepherd, A., et al., "Nutrition support: Risk factors, causes and physiology of malnutrition," Nursing Practice, 2009, Vol. 105, No. 4, pp. 18-20.
6. Shepherd, A., et al., "Nutrition support 2: Exploring different methods of administration," Nursing Practice, 2009, Vol. 105, No. 5, pp. 14-16.
7. U.S. Department of Health and Human Services, Food and Drug Administration, "Medical foods," https://www.fda.gov/food/guidance-documents-regulatory-information-topic-food-and-dietary-supplements/medical-foods-guidance-documents-regulatory-information Accessed 12/8/2020
8. Weissman, B., et al., "Enteral feeding," American Academy of Pediatrics, 2008, Vol. 28, pp. 105-106.

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 12/8/20, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
5/20/02	5/20/02	5/20/02	Joint policy established
6/24/04	6/24/04	7/26/04	Routine maintenance
5/19/05	5/19/05	5/19/05	Routine maintenance
11/1/06	8/30/06	10/29/06	Routine maintenance
11/1/07	8/21/07	10/27/07	Routine maintenance
5/1/08	2/19/08	3/14/08	Routine maintenance
5/1/09	2/10/09	2/10/09	Routine maintenance
5/1/11	2/15/11	3/3/11	Routine maintenance; policy criteria clarified
7/1/13	4/16/13	4/22/13	Routine maintenance
7/1/15	4/24/15	5/8/15	Routine maintenance
7/1/16	4/19/16	4/19/16	Routine maintenance
5/1/17	2/21/17	2/21/17	Routine maintenance Updated Government Regulations section Deleted procedure code B9000
5/1/18	2/20/18	2/20/18	Routine maintenance Updated Government Regulations section
5/1/19	2/19/19		Routine maintenance
5/1/20	2/18/20		Routine maintenance. Added asterisk to exclusions section, referencing Medical Formula for Inborn Errors of Metabolism policy
5/1/21	2/16/21		Routine maintenance.

Next Review Date: 1st Qtr, 2022

Pre-Consolidation Medical Policy History

Original Policy Date	Comments
BCN: 10/26/99	Revised: N/A
BCBSM: N/A	Revised: N/A

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: ENTERAL NUTRITION

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered, policy guidelines apply *BCN does not cover regular or special infant formulas for infants to one year of age.
BCNA (Medicare Advantage)	See Government Regulations section of policy.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the individual member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.