Review Criteria
Georgia Region

Title:	**ENTERAL SOLUTIONS**		
Department:	QUALITY RESOURCE MANAGEMENT	Page:	1 of 4
Section:	UTILIZATION MANAGEMENT	Policy Number:	03-08
Type:	( ) New	Effective Date:	5/2000
	(X) Reviewed / Revised	Date:	2/8/2016 3/20/2017 3/1/2018 2/28/2019 1/2/2020 1/21/2021 1/10/2022 2/21/2023

Purpose
This policy provides the indications and contraindications necessary for the Quality Resource Management staff to make the most appropriate decision related to the medical necessity of the procedure listed.

DIAGNOSIS/CONDITION: Disease of Upper GI System
Disease of Small Bowel
CPT-4/ HCPCS CODE AND DESCRIPTION: B4150-B4154; B4157
Note: Tricare Members, please check Policy Manual for coverage and exclusions

1.0 Background

- Enteral Solutions are nutritional solutions that are given via a tube to a patient in order to meet the nutritional needs of the patient and to maintain the weight and strength associated with the patient's overall health status. Although, in general, individuals are responsible for costs of their food, Enteral Solutions are covered in the Health Plan contract for all members, if the member's condition meets the coverage required by Medicare. When the Medicare criteria are met, the Enteral Solution, the tube, and any associated supplies and equipment are covered as a prosthetic device. According to Medicare criteria, the tube, nutritional solution, and other supplies are necessary to replace functions of the upper gastrointestinal system and/or small bowel.

2.0 Coverage Criteria:
In order for the Enteral Solution to be covered, **all** of the following criteria must be met:

- The patient must have:
  - A permanent nonfunction or disease of the structures that normally permit food to reach the small bowel, or

- A disease of the small bowel which permanently impairs digestion and absorption of an oral diet.

NOTE: The test of permanence will be met if the treating physician documents in the medical record that the patient's condition is long term and of indefinite duration (at least 3 months).

- The patient requires tube feedings to provide sufficient nutrients to maintain weight and strength associated with patient's overall health status.
- The Enteral Solution is the patient's **sole** source of nutrition. (NOTE: On a case by case, coverage will be considered when the Enteral Solution is the patient's primary source of nutrition, e.g. a patient with dysphagia who can swallow small amounts of food, **or member with an inborn error of metabolism that requires a specific formula supplement, such as phenylketonuria—for both pediatric and adult members.**)
- The patient's medical condition must require an Enteral Solution, as indicated on the Medicare approved list, in order to meet his/her nutritional needs.
- Enteral Solutions will **not** be covered when:
  - The patient's medical condition is temporary
  - The patient has a functioning gastrointestinal tract but needs tube feeding due to another type of medical condition (e.g. anorexia, mood disorders or end-stage disease)
  - Adequate nutrition can be maintained by dietary adjustments and/or oral supplements
  - The Enteral Solution is a dietary supplement
  - The Enteral Solution is consumed orally, or
  - The patient's nutritional needs can be met by using baby food or other blenderized grocery products.

3.0 Indications

- In order for coverage of Enteral Solutions to be approved, the treating physician must submit a request for authorization to the Quality Resource Management Department for review. Included with this request must be:
  - A statement from the treating physician regarding the patient's medical condition with specific attention to the disease or anatomical problem of the upper gastrointestinal tract or small bowel that has resulted in the patient having a permanent impairment requiring tube feedings.
  - An evaluation from a Registered Dietician or a physician regarding the patient's nutritional needs, with specific attention to:
    - Which Enteral Solution is required for the patient to meet his/her nutritional requirements and why that specific solution is being requested; and
    - The amount of Enteral Solution required per day or per month.
    - Approvals will be granted for 6 months, at which time the patient's medical condition will be re-evaluated to determine if the coverage criteria are still being met.

4.0 REFERENCES:

1. Core Curriculum for Intravenous Nursing. Corrigan et al. 2nd Edition. 2000 Lippincott Williams.
2. Cyclic Parenteral Nutrition Guidelines. Revised 2003. Kaiser Permanente NorCal Outpatient Infusion Pharmacy.
3. Pediatric Parenteral Nutrition. Baker et al. 2001 ASPEN Publishing.
4. The Science and Practice of Nutrition Support. ASPEN 2001. Kendall-Hunt Publishing.
5. Dipiro JT, Talbert RL, Yee GC, Wells BG, Posey LM. *Pharmacotherapy: A Pathophysiologic Approach*. 3rd
6. Guidelines for the Use of Parenteral and Enteral Nutrition in Adult and Pediatric Patients, *Journal of Parenteral and Enteral Nutrition*, August 1997.
7. Koda-Kimble MA, *Applied Therapeutics: The Clinical Use of Drugs*, Applied Therapeutics, Inc., 1996.
8. McKinnon BT. Home Care Issues in Nutrition Support. *Home Care Issues (Aspen Handbook)*. 1997.
9. Nutrition Support Team. Out Patient IV Pharmacy Adult Parenteral Nutrition Protocol. *Kaiser Permanente San Francisco Medical Center*.1997.
10. Strausberg KM. *Nutrition Support Handbook*. Harvey Whitney Publishers, Cincinnati OH. 1992.
11. CMS Determination: **180.2 - Enteral and Parenteral Nutritional Therapy**
   (Rev. 1, 10-03-03) CIM 65-10
   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 is 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.
12. Aetna (Nutrition Support) - 3/11/2011, 2/14/2014, 3/2019

Approval

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Luke Beno MD
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Date