Geisinger

Geisinger Health Plan Policies and Procedure Manual

Policy: MP247

Section: Medical Benefit Policy

Subject: Nutritional Supplements

Applicable Lines of Business

Commercial	**X**	**CHIP**	**X**
Medicare	**X**	**ACA**	**X**
Medicaid	**X**		

I. Policy: Nutritional Supplements

II. Purpose/Objective:

To provide a policy of coverage regarding Nutritional Supplements

III. Responsibility:

A. Medical Directors

B. Medical Management Department

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community;
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an

illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

Food Additives: Commercially available products such as fiber, calorie, and/or protein supplements, thickeners, vitamins, minerals, and products to aid in lactose digestion.

Grocery Items: Food items available for common consumption, including baby foods and self-blendarized food mixtures.

LOW-PROTEIN MODIFIED FOOD PRODUCTS
Low-protein modified food products are specially formulated to have less than 1 gram of protein per serving. Low-protein modified food products are intended for use under the direction of a physician for the dietary treatment of hereditary metabolic diseases but does not include a natural food that is naturally low in protein. Some examples of low-protein food products that are commercially available for purchase are breads, pasta, pastry shells, and rice pizza shells

DESCRIPTION:
Enteral nutrition is the method of providing food into the gastrointestinal tract via a percutaneous endoscopic gastrostomy (PEG) tube, jejunostomy tube (J-tube), percutaneous endoscopic jejunostomy (PEJ) tube, Gastrostomy tube (GT), or nasogastric (NG) tube in individuals with a functioning gastrointestinal tract but have a disorder that prevents normal chewing and swallowing, a disorder of the stomach but functioning intestine, or a disorder of the intestine but a functioning colon.

INDICATIONS:

All Business Segments:

Oral or tube delivered nutrition products or supplements used for the treatment of members with an established diagnosis of inborn error of metabolism (eg, phenylketonuria (PKU), homocystinuria, branch chain ketonuria, galactosemia, etc) with documentation of failure of conservative dietary interventions are covered as mandated by Act 191.

Prescription medical foods (formulas) administered orally or via a tube into the alimentary canal for members diagnosed with a rare genetic (inherited) inborn errors of metabolism (IEM), such as phenylketonuria (PKU), homocystinuria, branched-chain ketonuria, and galactosemia are covered for individuals of all ages who need administration of a formula that is manufactured for the therapeutic treatment and dietary management of individuals with IEMs and is administered under the direction of a physician.

The Following Indications Requires Prior Authorization by a Plan Medical Director or designee

Commercial Business Segments: (Coverage may vary by individual TPA)

Oral Nutritional Products:

Oral nutritional products are not covered unless mandated by law (**see Exclusions)**

Enteral nutrition (including administration, supplies and formula) may be considered medically necessary in members with:

Requirement of a feeding tube; **and**

a) Central nervous system injury or disease that results in partial or total inability to take nutrients orally and with functional gastrointestinal tract of sufficient absorptive capacity; **or**

b) Disease or injury (permanent or temporary) that requires the use of a feeding tube in insured individuals:
   i. Who are malnourished or are at risk of becoming malnourished; and
   ii. Who have inadequate or anticipated inadequate oral intake for at least 7 days; and
   iii. In whom the tube feeding provides the primary source of nutrition

Amino acid-based Elemental formula may be considered to be medically necessary in members age 5 years and younger when all of the following criteria are met:

- Medical record documentation of a laboratory or diagnostic test supported diagnosis of one or more of the following:
  a. Short gut syndrome
  b. IgE mediated allergies to food proteins
  c. Food protein induced enterocolitis syndrome
  d. Eosinophilic esophagitis (EE)
  e. Eosinophilic gastroenteritis (EG)
  f. Eosinophilic colitis
  g. Amino acid, organic acid and fatty acid metabolic and malabsorption disorder
  h. Cystic fibrosis

  and
- Documentation of at least two failed formula alternatives

Digestive enzyme cartridges (e.g. Relizorb) (B4105) used in conjunction with enteral nutrition therapy is considered to be medically necessary only when the following criteria are met:

- Member is aged 2 or above for the treatment of pancreatic insufficiency due to cystic fibrosis; and
- criteria for Enteral Nutrition has been met; and
- documented failure of pancreatic enzyme replacement therapy OR documented intolerance or hypersensitivity to all other digestive enzyme aids; and
- Failure to achieve or maintain target body mass index (at or above the 50th percentile)

Note: Other etiologies resulting in exocrine pancreatic insufficiency will be considered on a per-case basis

Medicare Business Segment:
please see LCD - Enteral Nutrition (L38955)
Article - Enteral Nutrition - Policy Article (A58833)

Oral Nutritional Products:
Oral nutritional supplementation is not covered under Medicare Part B.

Enteral Nutrition (including administration, supplies and formula) when ordered by a registered dietician, gastroenterologist or bariatrician may be considered medically necessary in members with:

Requirement of a feeding tube; **and**

a. Central nervous system injury or disease that results in partial or total inability to take nutrients orally and with functional gastrointestinal tract of sufficient absorptive capacity; **or**

b. Disease or injury (permanent or temporary) that requires the use of a feeding tube in insured individuals:
   i. Who are malnourished or are at risk of becoming malnourished; and
   ii. Who have inadequate or anticipated inadequate oral intake for at least 7 days; and
   iii. In whom the tube feeding provides the primary source of nutrition

Enteral formulas consisting of semi-synthetic intact protein/protein isolates (B4150 or B4152) are appropriate for the majority of beneficiaries requiring enteral nutrition.

The medical necessity for special enteral formulas (B4149, B4153, B4154, B4155, B4157, B4161, and B4162) must be justified in each case and supported by documentation of medical necessity. If a special enteral nutrition formula is provided and if the medical record does not document why that item is medically necessary, it will be denied as not reasonable and necessary. (Refer to the LCD-related Policy Article **(A58833)** for policy specific documentation requirements.)

If a pump (B9002) is ordered, there must be documentation in the beneficiary's medical record to justify its use (e.g., gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload, gastrostomy/jejunostomy tube used for feeding). If the medical necessity of the pump is not documented, the pump will be denied as not reasonable and necessary.

More than three nasogastric tubes (B4081, B4082, and B4083), or one gastrostomy/jejunostomy tube (B4087 or B4088) every three months is not reasonable and necessary.

In-line digestive enzyme cartridges (B4105) are reasonable and necessary for beneficiaries who:

A. meet the coverage criteria for enteral nutrition; AND
B. have a diagnosis of Exocrine Pancreatic Insufficiency (EPI)

More than two in-line digestive enzyme cartridges (B4105) per day will be denied as not reasonable and necessary

Medicaid Business Segment:

Oral or enteral nutrition products or supplements used for the treatment of members with an established diagnosis of inborn error of metabolism (eg, phenylketonuria (PKU) homocystinuria, branch chain ketonuria, galactosemia, etc) with documentation of failure of conservative dietary interventions are covered as mandated by Act 191

Oral Nutritional Products:

For members under age 21 years:

Each case will be determined based on medical necessity. Physician documentation must provide all of the following:

- a description of the member's clinical condition that clearly outlines why the nutritional needs cannot be met through dietary modification to increase caloric intake (snacks, higher calorie/protein foods)
- A description of the member's current nutritional status (eg, height, weight, percentiles for pediatric members)
- A prescription or order including the product, administration route and rate of intake
- An estimated duration of therapy
- For oral nutritional supplementation expected to be required long term (months), documentation of a nutritional assessment needs to be provided that includes an assessment of current caloric intake, caloric needs, and why dietary modification cannot meet those needs.

Pasteurized Human Donor Breast Milk

Inpatient Infant

Pasteurized donor human milk (PDHM) is covered for an infant who is younger than twelve months of age based on the infant's corrected gestational age, who is receiving care in an inpatient setting and has any of the following health conditions:

(1) An infant birth weight equal to or less than one thousand eight hundred grams.
(2) An infant gestational age equal to or less than thirty-four weeks.
(3) A high risk for development of necrotizing enterocolitis, bronchopulmonary dysplasia, sepsis or retinopathy of prematurity.
(4) A congenital or acquired gastrointestinal condition or other serious medical condition associated with long-term feeding or malabsorption complications.
(5) Congenital heart disease requiring surgery in the first year of life.
(6) Has had or will have an organ or bone marrow transplant or has an immunologic deficiency.
(7) Renal disease requiring dialysis in the first year of life.
(8) Infant hypoglycemia or jaundice.
(9) Neonatal abstinence syndrome.
(10) Any other health condition for which the use of PDHM is medically necessary as determined by the Department.

Outpatient Infant – REQUIRES PRIOR AUTHORIZATION

PDHM is covered for an infant who is younger than twelve months of age based on the infant's corrected gestational age, who is receiving care in an outpatient setting and has any of the following health conditions:

(1) A congenital or acquired gastrointestinal condition or other serious medical condition associated with long-term feeding or malabsorption complications.
(2) Congenital heart disease requiring surgery in the first year of life.
(3) Has had or will have an organ or bone marrow transplant or has an immunologic deficiency.
(4) A history of sepsis.
(5) Renal disease requiring dialysis in the first year of life.
(6) Any other health condition for which the use of PDHM is medically necessary as determined by the Department.

- Donor human milk may be used for high-risk infants when the mother's milk is not available or the mother cannot provide milk. Priority will be given to providing donor human milk to infants <1500 g birth weight.
- The donor must be identified and screened using methods such as those currently used by HMBANA milk banks or other established commercial milk banks.
- The donor milk is pasteurized according to accepted standards.

For members age 21 years and older:

Commercial oral nutrition products are covered if such products constitute 50% or more of total patient caloric intake and are found to be medically necessary. The following criteria must be met:

- Member must have a documented medical condition that limits his or her ability to ingest, digest, or absorb regular food; and
- reversible causes have been ruled out; and
- nutritional assessment has been completed to document current caloric intake, caloric needs, and why dietary modification cannot meet those needs

Enteral Nutrition:
Enteral Nutrition (including administration, supplies and formula) when ordered by a registered dietician, gastroenterologist or bariatrician may be considered medically necessary in members with:

Requirement of a feeding tube; and

a. Central nervous system injury or disease that results in partial or total inability to take nutrients orally and with functional gastrointestinal tract of sufficient absorptive capacity; **or**

b. Disease or injury (permanent or temporary) that requires the use of a feeding tube in members:

   i. Who are malnourished or are at risk of becoming malnourished; and
   ii. Who have inadequate or anticipated inadequate oral intake for at least 7 days; and
   iii. In whom the tube feeding provides the primary source of nutrition

c. Human Immunodeficiency Virus (HIV) /Acquired Immunodeficiency Syndrome (AIDS)

A limit of 960 units per month equating to 96,000 calories per month, or 3,000 calories per day, for 32 days, which will meet the daily caloric needs of the vast majority of members will be considered medically necessary. However, if needed, an exception of the limits may be requested. A one-month supply will be provided each 32 days.

Amino acid-based Elemental formula may be considered to be medically necessary in members age 21 years and younger when all of the following criteria are met:

- Medical record documentation of a laboratory or diagnostic test supported diagnosis of one or more of the following:
  a.Short gut syndrome
  b.IgE mediated allergies to food proteins
  c. Food protein induced enterocolitis syndrome
  d.Eosinophilic esophagitis (EE)
  e.Eosinophilic gastroenteritis (EG)
  f.Eosinophilic colitis
  g.Amino acid, organic acid and fatty acid metabolic and malabsorption disorder
  h.Cystic fibrosis

and

- Documentation of at least two failed formula alternatives

Digestive enzyme cartridges (e.g. Relizorb) (B4105)
NOTE: Digestive enzyme cartridges (e.g. Relizorb) used in conjunction with enteral nutrition therapy may be considered on a per-case basis through the Program Exception process for Medicaid Business segment members ages 2 years and older with exocrine pancreatic insufficiency who are partially or completely unable to hydrolyze fats in enteral formula.

LIMITATION:
Standard formula for newborns or infants is not considered to be medically necessary and is therefore not covered. Standard infant formula for normal infants or for infants with medical illness or disability is considered to be non-medical in nature, as nutrition is a normal need for all infants.

EXCLUSIONS:

Commercial Business Segment:

Oral nutrition products and**/**or supplements **NOT** used to treat inborn errors of metabolism are **NOT COVERED** including, but not limited to:

- Formula or Supplements to treat a deficient diet or to provide an alternative source of nutrition in conditions such as, but not limited to, allergies, obesity, hypo- or hyper-glycemia **and** gastrointestinal disorders; **or**
- Lactose-free foods; **or**
- Banked breast milk; **or**
- Standardized or specialized infant formulas (including over-the-counter infant formulas (such as Similac, Enfamil, etc.)

ALL BUSINESS SEGMENTS: (with exceptions as noted)

Grocery items and food additives as defined under section V. Additional Definitions or medical food products are **NOT COVERED**.

Enteral products for the diagnosis of “failure to thrive” are **NOT COVERED**.

Enteral nutrition for temporary impairments is **NOT COVERED.**

Enteral products for the purpose of augmenting normal dietary sources of nutrition are **NOT COVERED**.

Orally administered enteral nutrition products, related supplies and equipment is **NOT COVERED.**

Food thickeners (B4100), baby food, and other regular grocery products that can be blenderized and used with the enteral system will be denied as **NOT COVERED. (Exclusion for B4100 NOT Applicable to Medicaid Business Segment)**

Enteral formula additives are **NOT SEPERATELY REIMBURSED.**

Digestive enzyme cartridges (e.g. Relizorb) used in conjunction with enteral nutrition therapy not meeting criteria listed in specific line of business Indications sections is considered to be of unproven benefit and therefore not medically necessary and **NOT COVERED. The Cystic Fibrosis Foundation does not recommend for or against a specific method of providing pancreatic enzyme therapy during enteral tube feedings in individuals with CF. The North American Society of Pediatric Gastroenterology, Hepatology and Nutrition Pancreas Committee concluded that the current literature reveals a lack of data in the area of nutrition in pediatric pancreatology. This limitation has led to most recommendations being expert recommendations rather than evidence-based (Not applicable to Medicare lob)**

NOTE: May be considered on a per-case basis through the Program Exception process for Medicaid Business segment members ages 5 years and older with exocrine pancreatic insufficiency who are partially or completely unable to hydrolyze fats in enteral formula.

Low-protein modified food products are **NOT COVERED** for inherited errors of metabolism because they do not meet the policy definition of medical foods or nutritional formulas. This information is in accordance with the state mandate. Pennsylvania Mandate does not require coverage for low-protein modified food products such as breads, pasta, pastry

shells, and rice pizza shells that can be purchased commercially without a prescription and are used in the dietary management of rare hereditary genetic metabolic disorders such as PKU, branched chain-ketonuria, galactosemia, and homocystinuria.

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

CODING ASSOCIATED WITH: Enteral nutrition

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements

CPT/HCPCS Coding:

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
B4082 NASOGASTRIC TUBING WITHOUT STYLET
B4083 STOMACH TUBE - LEVINE TYPE
B4087 GASTROSTOMY/JEJUNOSTOMY TUBE, STANDARD, ANY MATERIAL, ANY TYPE, EACH
B4088 GASTROSTOMY/JEJUNOSTOMY TUBE, LOW-PROFILE, ANY MATERIAL, ANY TYPE, EACH
B4100 FOOD THICKENER, ADMINISTERED ORALLY, PER OUNCE – **{not covered}**
B4102 ENTERAL FORMULA, FOR ADULTS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G., CLEAR LIQUIDS), 500 ML = 1 UNIT - **{not covered}**
B4103 ENTERAL FORMULA, FOR PEDIATRICS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G., CLEAR LIQUIDS), 500 ML = 1 UNIT - **{not covered}**
B4104 ADDITIVE FOR ENTERAL FORMULA (E.G., FIBER) – **{not separately reimbursed}**
B4105 IN-LINE CARTRIDGE CONTAINING DIGESTIVE ENZYME(S) FOR ENTERAL FEEDING, EACH
B4148 ENTERAL FEEDING SUPPLY KIT; ELASTOMERIC CONTROL FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE
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 FEEDINGTUBE, 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
B9000
B9002 ENTERAL NUTRITION INFUSION PUMP, ANY TYPEB
B9998
T2101 – human breast milk processing, storage and distribution only
S9342 home therapy; enteral nutrition via pump; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem
S9343 home therapy; enteral nutrition via bolus; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem
S9432 Medical foods for non-inborn errors of metabolism
S9433 medical food nutritionally complete, administered orally, providing 100% of nutritional intake
S9435 Medical foods for inborn errors of metabolism
S9434 Modified solid food supplements for inborn errors of metabolism

For amino acid elemental formula:
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

B4105- in-line cartridge containing digestive enzyme(s) for enteral feeding,

LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

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This policy will be revised as necessary and reviewed no less than annually.

Devised: 12/10

Revised: 7/13, 9/15 (added Act 158 provisions); 7/16; 8/17 (added human donor breast milk); 6/18 (add exclusion); 7/19 (add indication and exclusion) 5/21 (add coverage and exclusion language); 5/23 (clarify exclusions by lob); 2/24 (update PDHM coverage, revise medicare coverage, revise exclusions); 5/24 (revise digestive enzyme cartridge coverage)

Reviewed: 12/11, 12/12, 8/14, 7/20, 5/22

CMS UM Oversight Committee Approval: 12/23