Clinical Policy: Oral Enteral Nutrition

Reference Number: WA.CP.MP.507
Date of Last Revision: 09/23
Effective Date: 11/01/24

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity guidelines for oral enteral nutrition. For total parenteral nutrition, see CP.MP.163, Total Parenteral Nutrition and Intradialytic Parenteral Nutrition.

Policy/Criteria

I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority, that oral enteral nutrition is considered **medically necessary** as noted:

A. Oral Enteral Nutrition (Modifier –BO) must meet all criteria

1. Member is age 20 or younger (age 21 and over request for PKU formula requires Exception To Rule)
2. Diagnosis must support the member's need for the orally administered enteral nutrition product as demonstrated through one or more of the following diagnoses:
   a. Dysphagia (oral, oropharyngeal or pharyngeal)
   b. "Failure to thrive" or "Feeding difficulties" (Only applicable toward criteria if the underlying medical or behavioral cause has already been identified and addressed)
   c. Inherited Metabolic Disorders: Amino acid, fatty acid, or carbohydrate metabolic disorders, including phenylketonuria (PKU)
3. Required to treat medical conditions when no equally effective, less costly alternative is available to treat the client's condition
4. If member requires more than 6 months to transition to a diet of traditional food or food products (which can be purchased for the member as grocery products), documentation must also include all of the following:
   a. The member nutrition care plan, including steps to transition the client to food or food products, if possible, or document why the member cannot transition to food or food products. (Any updates from subsequent Registered Dietician re-evaluations must be included)
   b. Updates to the member's growth chart is documented in medical records
   c. Progress notes show through regular follow up and weight checks how the requested product is treating the member's growth and nutrient deficits, or is necessary to maintain the member's growth or nutrient status
   d. Referrals, if necessary, to other health care providers treating related medical or mental health conditions
   e. Documentation of any communication the treating provider has had with other providers directly or indirectly treating the client's growth or nutrient deficits while the client is receiving orally administered enteral nutrition products

B. Thickeners must always meet criteria 1 and 2. Children under one year must also meet criteria 3.
   1. Member is age 20 or younger
   2. Diagnosis of oral, oropharyngeal or pharyngeal dysphagia
      a. Documented by video fluoroscopy or
      b. If no video fluoroscopy is available, documentation of the findings of the swallow evaluation including information on trials of different food consistencies that lead to the recommendation of a particular dysphagia diet.
   3. Member under age one year
      a. Due to Food and Drug Administration and American Academy of Pediatrics safety warnings about gum thickeners and infants, requests for prior auth must include documentation of other strategies used to address dysphagia and why the strategies failed and
      b. Confirmation that the parents or guardians have been advised of the warning and agree that the benefit outweighs the risk.

C. Tube-Delivered Enteral Nutrition (Modifier –BA) Formula and equipment are medically necessary for members/enrollees with a feeding tube to support the administration of nutrition.

II. All members under age five who qualify for supplemental nutrition from the Women, Infants and Children (WIC) nutrition program must receive products and formulas directly from that program. Coverage of oral enteral nutrition to children under 5 years is provided only when the member meets one of the following criteria:

A. Not eligible for the WIC program
B. Eligible for WIC, but member's need for an oral enteral nutrition product or formula exceeds the amount allowed by WIC
C. Eligible for WIC, but a medically necessary product or formula is not available through the WIC program

Background

This policy is based on Washington State Health Care Authority (HCA) Billing Guidelines. Oral enteral nutrition refers to products, equipment, and supplies related to medically necessary nutrition when a member is unable to consume enough traditional food to meet nutritional requirements. Enteral nutrition may be provided orally or via feeding tube. It is not a food benefit, such as Basic Food in Washington and WIC.

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 2019, 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. 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.

HCPCS Codes	Description
B4034	Enteral feed sup kit syringe per day
B4035	Enteral feed sup kit pump per day
B4036	Enteral feed sup kit gravity per day
B4081	Enteral ng tubing w/ stylet
B4082	Enteral ng tying w/o stylet
B4083	Enteral stomach tube levine
B4087	Gastro/jejuno tube, standard
B4088	Gastro/jejuno tube, low-profile
B4100	Food thickener, oral
B4102	Enteral Formula adult fluids and electro
B4103	EF ped fluid and electrolyte
B4149	EF blenderized foods
B4150	EF complete w/ intact nutrient
B4152	EF calorie dense >= 1.5 kcal
B4153	EF hydrolyzed amino acids
B4154	EF spec metabolic noninherit
B4155	EF incomplete/modular
B4157	EF special metabolic inherit
B4158	EF ped complete intact nut
B4159	EF ped complete soy based
B4160	EF ped caloric dense >= 0.7 kcal
B4161	EF ped hydrolyzed amino acid
B4162	EF ped spec metabolic inherit
B9002	Enteral nutrition infusion pump, rental
B9998	Enteral supply not otherwise classified
E0776	IV pole
E1399	Durable medical equipment, miscellaneous
K0739	Repair/service DME

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed. Previously WA.UM.41	07/19	07/19
Added clinical criteria to assist clinical review. Removed modifiers from code list. Updated reference.	03/20	04/20
Annual review. Updated reference. Added E1399, K0739	01/21	02/21
Updated reference. Removed criteria for tube feedings	05/21	06/21
Annual Review. Changed “Review Date” in the header to “Date of Last Revision” and “Date” in the revision log header to “Revision Date.” Replaced "members" with "members/enrollees".	05/22	05/22
Annual review. Reference updated. Section I.A.4. additional criteria points d. and e. added to correspond to HCA Billing Guidelines.	05/23	05/23

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Added Exception to the Rule comment for adults requesting PKU formula	08/23	09/23
Annual review. References updated.	08/24	09/24

References

1. Washington State Health Care Authority. Enteral Nutrition Billing Guide. https://www.hca.wa.gov/assets/billers-and-providers/Enteral-Nutrition-bg-20240701.pdf. Revision effective July 1, 2024.

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/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, 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.