

Coverage of any medical intervention discussed in a Dean Health Plan medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate or summary plan description (SPD) and to applicable state and/or federal laws.

Outpatient Enteral Therapy

MP9069

Covered Service: Yes

Prior Authorization

Required: Yes

Additional Information:

Further information on amino acid-based elemental formulas can be found in the policy: [Amino Acid Based Formulas MP9355](#).

Most Member Certificates or Summary Plan Descriptions (SPD) exclude coverage of enteral feeds unless they are the sole source of nutrition, however, enteral feedings of standard infant formulas, standard baby food, and regular grocery products used in blenderized formulas are excluded regardless of whether they are the sole source of nutrition.

Coverage may vary according to the terms of the Member Certificate and Summary Plan Description. Enteral therapy may also be described as food in the Member Certificate and Summary Plan Description.

Medicare Policy:

Prior authorization is dependent on the member's Medicare coverage. Prior authorization is not required for Medicare Cost (Dean Care Gold) and Medicare Supplement (Select) when this service is provided by participating providers. Prior authorization is required if a member has Medicare primary and Dean Health Plan secondary coverage. This policy is not applicable to our Medicare Replacement product (Dean Advantage).

BadgerCare Plus Policy:

Prior authorization is not required for enteral nutrition. (If formula is being used for oral feeding a PA is required (modifier BO – formula taken orally), Dean Health Plan covers this benefit when BadgerCare Plus also covers the benefit. Please refer to Forward Health:

<https://www.forwardhealth.wi.gov/WIPortal/Default.aspx>

Dean Health Plan Medical Policy:

1.0 Synthetic or semi-synthetic enteral feedings **require** prior authorization through the Health Services Division and are considered medically necessary for members that meet **ALL** the following criteria:

- 1.1 Enteral feedings are the member's sole source of nutrition (dietary adjustment or oral supplements are contraindicated or are not possible).

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- 1.1.1 Members which are required, as a part of the physician's prescribed treatment plan, to ingest a small amount of oral feeding may be considered meeting this criteria when the enteral feeding formula comprises 60% or more of caloric nutritional intake; **AND**
- 1.2 The member has a functional intestinal tract, and **ONE** of the following conditions are met:
 - 1.2.1 Non-function or disease of the pharynx, esophagus, or stomach that prevents nutrients from reaching the small intestine;
 - 1.2.1.1 Non-function or disease of other organs does not meet this criteria; **OR**
 - 1.2.2 Central nervous system (CNS) disease leading directly to interference with the neuromuscular coordination chewing and swallowing such that a risk of aspiration exists;
 - 1.2.2.1 CNS disease that does not interfere with chewing and swallowing and cause risk of aspiration does not meet this criteria; **AND**
- 1.3 A naso-gastric, jejunostomy, or gastrostomy tube is in place for administering the feedings.
- 2.0 Enteral formula consisting of manufactured blenderized natural foods with intact nutrients, includes proteins, carbohydrate, vitamins, mineral and may include fiber, administered through an enteral feeding tube (HCPCS B4149) **require** prior authorization through the Health Services Division and are considered medically necessary when **ALL** of the following criteria are met:
 - 2.1 All criteria of (1.0) are met; **AND**
 - 2.2 Documentation indicates the member has **ONE** of the following:
 - 2.2.1 Intolerance to a semi-synthetic enteral product; **OR**
 - 2.2.2 Severe allergic reaction to a semi-synthetic enteral product.
- 3.0 The following are excluded whether they are the sole source of nutrition unless specifically included in the Member Certificate or Summary Plan Description:
 - 3.1 Regular grocery products used in blenderized formulas
 - 3.2 Enteral feedings of standard infant formulas or standard baby food
 - 3.3 Enteral nutrition formulas that are administered orally and supplies related to oral administration
 - 3.4 Digestive enzyme cartridges (e.g. RELiZORB, HCPCS B4105) used in conjunction with enteral nutrition therapy are considered experimental and investigational and therefore are not covered.
- 4.0 Supplies and equipment necessary to accomplish enteral formula administration are covered according to the terms of the Member Certificate or Summary Plan Description.

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	Committee/Source	Date(s)
Document Created:	UR/Management Committee	January 10, 1990
Revised:	Utilization Management Committee/ Customer Service	November 11, 1999
	Medical Director Committee/Medical Affairs	December 18, 2013
	Medical Director Committee/Medical Affairs	July 16, 2014
	Medical Policy Committee/Quality and Care Management Division	July 19, 2017
	Medical Policy Committee/Health Services Division	August 15, 2018
	Medical Policy Committee/Health Services Division	August 21, 2019
	Medical Policy Committee/Health Services Division	July 15, 2020
	Medical Policy Committee/Health Services Division	March 17, 2021
	Medical Policy Committee/Health Services Division	March 16, 2022
	Medical Policy Committee/Health Services Division	April 20, 2022
	Medical Policy Committee/Health Services Division	April 19, 2023
	Medical Policy Committee/Health Services Division	March 20, 2024
Reviewed:	Health Services/Medicare, 3/96	February 9, 1998
	Health Services	February 12, 1999
	Managed Care Division/ Medical Affairs Department	March 20, 2000
	Managed Care Division / Medical Affairs Department	April 11, 2001
	UMC/CMO/Director Utilization Management	March 13, 2002
	UM Committee (UMC)/Director UM/UMC Chair	March 12, 2003
	UM Committee (UMC)/Director UM/UMC Chair	March 10, 2004
	UM Committee (UMC)/Director UM/UMC Chair	March 9, 2005
	Reformatted	September 2005
	UM Committee (UMC)/Director UM/UMC Chair	March 8, 2006
	Utilization Management Committee/Medical Affairs	November 8, 2006
	Utilization Management Committee/Medical Affairs	December 13, 2006
	Utilization Management Committee/Medical Affairs	February 14, 2007
	UM Committee (UMC)/Director UM/UMC Chair	March 14, 2007
	UM Committee (UMC)/Director UM/UMC Chair	March 12, 2008
	UM Committee (UMC)/Director UM/UMC Chair	April 8, 2009
	Medical Director Committee/Medical Affairs	July 21, 2010
	Medical Director Committee/Medical Affairs	July 27, 2011
	Medical Director Committee/Medical Affairs	July 20, 2012
	Medical Director Committee/Medical Affairs	August 15, 2012
	Medical Director Committee/Medical Affairs	July 17, 2013
	Medical Director Committee/Medical Affairs	December 18, 2013
	Medical Director Committee/Medical Affairs	July 16, 2014
	Medical Director Committee/Medical Affairs	July 15, 2015
	Medical Policy Committee/Quality and Care Management Division	July 20, 2016
	Medical Policy Committee/Quality and Care Management Division	August 17, 2016

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Published: 04/01/2024

Effective: 04/01/2024