Enteral Products and Supplies
DME-007

Iowa Medicaid Program	Prior Authorization	**Effective Date**	07/01/2005
Revision Number	10	**Last Reviewed**	07/17/2026
Reviewed By	Medicaid Medical Director	**Next Review**	07/16/2027
Approved By	Medicaid Clinical Advisory Committee	**Approved Date**	01/16/2015

Criteria

Daily enteral nutrition therapy is considered reasonable and necessary when the member has **ONE** of the following:

1. A metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products; **OR**
2. Severe pathology of the body that will not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member's general condition; **OR**
3. A medication-induced nutritional deficiency; **OR**
4. Milk or food allergies are covered indications only for children under 5 years of age; **OR**
5. Metabolic formulas as an oral supplement are approvable for a member with a diagnosis affecting their ability to adequately metabolize nutrients needed to maintain a healthy nutritional status regardless of percentage of daily caloric intake; **OR**
6. Food thickener may be approved through prior authorization for a member with a diagnosis supporting the need for thickened liquids as evidenced by the results of a swallow study; **OR**
7. Pump rental may be approved through prior authorization if any of the following are present:
   a. The member has a medical diagnosis that necessitates the use of a pump versus gravity; **OR**
   b. The member has a jejunostomy or nasogastric feeding tube; **OR**
   c. The member is receiving enteral formula; **OR**
   d. The administration rate is <100 ml/hr.

Examples of conditions that do **NOT** justify approval of enteral nutrition therapy are:

1. Weight-loss diets.
2. Wired-shut jaws.

3. Diabetic diets.
4. Milk or food allergies for members five years of age and older.
5. The use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member.

Oral supplementation of a regular diet is reimbursable when:

1. Member is unable to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology; **AND**
2. Supplementation is necessary to provide 51 percent or more of the daily caloric intake **OR** the use of oral nutritional products is determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition (prescriber should provide the guidelines). Such conditions may include:
   a. Acquired immunodeficiency syndrome; **OR**
   b. Burns; **OR**
   c. Cancer; **OR**
   d. Failure to thrive syndrome; **OR**
   e. Problems with the kidney, liver, lungs, pancreas, or stomach; **OR**
   f. Prolonged infections; **OR**
   g. Surgery; **OR**
   h. Trauma; **OR**
   i. Oral aversion or other psychological condition that limits oral intake.

Coding

The following list of codes are provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS/CPT code is inappropriate.

HCPCS	Description
B4100	Food thickener, administered orally, per ounce.
B9002	Enteral nutrition infusion pump, any type.

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.

3. Medical technology is constantly evolving and Iowa Medicaid reserves the right to review and update medical policy on an annual or as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

Provider Manual: Durable Medical Equipment: 4.Nutritional Products and Supplies

Iowa Administrative Code (IAC) 441.78.10(3)b(3), 441-78.10(5)l, and 441-78.28(1)c

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]			[#]
Signature			

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]			[#]
Signature			

Change Date	Changed By	Description of Change	Version
07/17/2026	CAC	Annual Review.	10
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
07/18/2025	CAC	Annual review. Removed reference to oral supplement in criteria. Updates references.	9
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**

Criteria Change History

07/19/2024	CAC	Annual review. Removed an oil based in 7c. Reformatted Prior Authorization.	8
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
07/21/2023	CAC	Annual review.	7
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
07/15/2022	CAC	Annual review.	6
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
07/16/2021	CAC	Annual review. Formatting changes. Added Compliance section.	5
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
01/16/2015	CAC		4
Signature C. David Smith, MD			
Change Date	**Changed By**	**Description of Change**	**Version**
12/12/2013	Medical Director	"The provider must supply the member's daily caloric need OR the amount of calories the member consumes" - change OR to AND.	3
Signature Jason Kessler, MD			
Change Date	**Changed By**	**Description of Change**	**Version**
02/18/2013	Policy	Changed reference to 51 percent of daily caloric intake to be provided by supplement.	2
Signature			
Change Date	**Changed By**	**Description of Change**	**Version**
01/18/2013	CAC	Replace Criteria #1 with new information. Criteria #2 add "indications" and "only". Criteria #4 remove effective date. After Criteria #5 add new examples and information on oral supplementation. References - Add IAC information.	1
Signature William (Bill) Jagiello, DO			

CAC = Medicaid Clinical Advisory Committee