STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Enteral Products and Supplies
DME-007

Iowa Medicaid Program:	Prior Authorization	**Effective Date:**	7/1/2005
Revision Number:	7	**Last Rev Date:**	7/21/2023
Reviewed By:	Medicaid Medical Director	**Next Rev Date:**	7/19/2024
Approved By:	Medicaid Clinical Advisory Committee	**Approved Date:**	1/16/2015

Criteria

Prior authorization is required.

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 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 an oil based 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.

If an oral supplement is being requested, the provider must supply the member's daily caloric need **AND** the amount of calories that the member consumes daily from regular/pureed foods.

Coding and Product Information

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
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.
B4100	Food thickener, administered orally, per ounce.
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit.
B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit.
B4104	Additive for enteral formula (e.g., fiber).
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.

HCPCS	Description
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 feeding tube, 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.
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.
B9002	Enteral nutrition infusion pump, any type.
S9435	Medical foods for inborn errors of metabolism.

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. Medical necessity guidelines are developed for selected physician administered medications found to be safe and proven to be effective in a limited, defined population or clinical circumstances. 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, pages 33 through 35.

Iowa Administrative Code (IAC) 441-78.10(3)c(2) to 78.10(3)c(3)3.

IAC 441-78.28(1)c(1) to 78.28(1)c(3).

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

Signature

Change Date	Changed By	Description of Change	Version

Signature

Change Date	Changed By	Description of Change	Version
7/21/2023	CAC	Annual review.	7

Signature
William (Bill) Jagiello, DO

Change Date	Changed By	Description of Change	Version
7/15/2022	CAC	Annual review.	6

Signature
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Change Date	Changed By	Description of Change	Version
7/16/2021	CAC	Annual review. Formatting changes. Added Compliance section.	5

Signature
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Change Date	Changed By	Description of Change	Version
1/16/2015	CAC	Added last paragraph in References.	4

Signature
C. David Smith, MD William (Bill) Jagiello, DO

Criteria Change History (continued)

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
2/8/2013	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
1/18/2013	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			