



Enteral Nutrition

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Purpose:

To provide enteral nutrition guidelines for Population Health and Provider Alliances associates to reference when making benefit determinations.

Coverage Guidelines

- Initiation or continuation of enteral nutrition in the home setting will only be considered in Members who are clinically stable, have an appropriate indication for enteral nutrition, are able to be evaluated in the home, and are capable of being educated in the safe administration of the therapy.
- For Adult and Pediatric Commercial Members whose DME benefits cover nutritional support, but whose contract does not specify how it is covered, enteral feeding solution will be covered up to any applicable contractual limits when ALL of the following are met:
 1. Nutritional solution can be obtained with a prescription only (over-the-counter infant formula is not covered);
 2. The nutritional solution is the sole source of nutrition;
 3. The nutritional solution has to be administered by feeding tube or G-tube, and is not taken orally;
 4. The absorption impairment that requires nutritional feeding must be considered, in the judgment of the doctor and substantiated in the medical record, to be expected to exceed three (3) months (90 days).
- Examples of some impairments are dysphagia due to CVA or other neurological condition, Esophageal obstruction, Gastric outlet obstruction, etc.

Exclusion Criteria (this list is not to be considered all-inclusive):

- Diagnosis of depression, dementia, or anorexia is not covered, unless there is some other covered absorption impairment noted.



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References:

1. A.S.P.E.N. Board of Directors and the Clinical Guidelines Task Force. Guidelines for the use of parenteral and enteral nutrition in adult and pediatric patients [published errata appears in *JPEN J Parenter Enteral Nutr* 2002; 26:144]. *JPEN J Parenter Enteral Nutr*. 2002;26(suppl 1):1SA–138SA.
2. American Dietetic Association Board of Directors. Position of the American Dietetic Association: ethical and legal issues in nutrition, hydration, and feeding. *J Am Dietet Assoc*. 2002; 102:716–726.
3. Centers for Medicare and Medicaid Services (CMS). Enteral and Parenteral nutritional therapy covered as a prosthetic device (NCD 180.2). National Coverage Analyses. Baltimore, MD: CMS; April 2008.

Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed's benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.