

ENTERAL NUTRITION:

Prior authorization required
CMN REQUIRED (SFN 782)

Nutritional supplementation coverage through Medicaid is considered optional by CMS. The following outlines ND Medicaid's defined coverage of these products:

Approval Criteria:

1. Nasogastric or gastrostomy tube feeding
2. Malabsorption diagnoses including:
 - a. Short Bowel (Gut) Syndrome
 - b. Crohn's Disease
 - c. Pancreatic Insufficiency
3. Limited volumetric tolerance requiring a concentrated source of nutrition (i.e., athetoid cerebral palsy with high metabolic rate)
4. Severe swallowing and eating disorders where consistency and nutritional requirements can be met only using commercial nutritional supplements, including (refer below to non-covered swallowing and eating disorders):
 - a. Dysphagia due to excoriation of oral-pharyngeal mucosa
 - b. Mechanical swallowing dysfunction secondary to a disease process such as:
 - i. Cancer or herpetic stomatitis
 - ii. Other oral-pharyngeal tissue injury
5. Weight loss, with documentation providing the following information:
 - a. Normal weight, percentile weight, and number of pounds lost in a specified time period
 - b. A specific medical problem, which has caused the weight loss
 - c. Specific reasons why a diet of normal or pureed food cannot suffice
6. Effective 1/1/2012 coverage added for HCPC code B4154 (Nutritionally complete formula, for special metabolic needs, excludes inherited disease of metabolism). Examples include: Glucerna, Pulmocare, Renalcal, etc., Covered under the following criteria:
 - a. Patient must have a nasogastric or gastrostomy tube
 - b. The enteral nutrition formula must be the patients sole source (90%+) of nutrition

Non-Covered Diagnoses:

1. Swallowing disorders, which may lead to aspiration
2. Swallowing disorders, which are psychosomatic in nature, as in anorexia or dementia
3. Reduced appetite due to side effects of drug products, as with methylphenidate, amphetamines, appetite suppressants, etc.
4. Mastication problems due to dentition problems

Products considered for coverage:

ND Medicaid will only offer coverage for the following:

1. Products classified by First Data Bank (FDB) as Therapeutic Class Code, Specific C5F (e.g. Ensure, Pediasure, Boost, Resource)
2. B4154 (Nutritionally complete formula , for special metabolic needs, excludes inherited disease of metabolism)
 - a. Coverage for these B4154 products is effective for dates of service 1/1/2012 and after
 - b. Coverage for these B4154 products will only be allowed for patients
 - i. With nasogastric or gastrostomy tubes
 - ii. When the product is their sole source (90% +) of nutrition
3. Food thickeners

Products excluded from coverage:

ND Medicaid will not offer coverage for the following:

1. Infant formulas, nucleic acid/ nucleotide supplements, protein replacement, diet foods, geriatric supplements, sport shakes
2. Any product when used in amounts less than 51% of daily intake (must essentially be majority source of nutrition)
3. Nutritional products for persons living in TLC facilities (enteral products are included in the per diem).

Additional covered supplies:

1. Some enteral patients may experience complications associated with syringe or gravity method of administration and require a more controlled administration method. The pump may be covered if medically necessary and ordered by the physician. Documentation will be required to accompany the prior authorization to support pump therapy. (Example: gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload, gastrostomy/jejunostomy tube used for feeding). If the medical necessity of the pump is not documented, the pump will be denied as not medically necessary.
2. Supply kits (B4034-B4036): Must correspond to the method of administration. Allowed one supply kit per day or maximum of 31 per month. Supply kits include all supplies, other than the feeding tube itself, required for the administration of enteral nutrients to the patient for one day.

- More than one gastrostomy/jejunostomy tube, or three nasogastric tubes every 3 months are rarely medically necessary.
- Dressings/anchoring devices are included in the supply kit and will not be paid separately.
- A revised CMN is necessary if the number of units per month, method of administration, route of administration or type of nutrition has changed.
- Recertification yearly unless required earlier due to change in orders/quantity.



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- No more than one month's supply of enteral nutrients, equipment or supplies are allowed for one month's prospective billing.
- B4087 and B4088 are the only codes allowed for gastrostomy/jejunostomy tubes. Must not use B9998.
- Pump & pump supplies are allowed if enteral nutrition is ordered for an infant. The nutrition is non-covered / no exception as infant formulas are non-covered regardless of age of recipient.

Policy Effective 1/1/2012