

# Enteral Nutrition (Oral and Tube Feeding) (for Louisiana Only)

**Policy Number:** CS136LA.L  
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[Instructions for Use](#)

Content mandated by Louisiana Department of Health

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## Application

This Medical Policy only applies to the state of Louisiana. The coverage rationale contained in this policy represents Louisiana Medicaid coverage policy and is set forth below in accordance with State requirements.

## Coverage Rationale

### Enteral Nutrition

Enteral therapy or oral nutritional supplements may be provided safely and effectively in the home by non-professional persons who have undergone special training. Medicaid will not pay for any services furnished by non-physician professionals.

Enteral nutritional therapy is considered reasonable and necessary when medical documentation, such as hospital records and clinical findings, support an independent conclusion the beneficiary has a permanently inoperative internal body organ or function which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the beneficiary’s general condition. For purposes of this policy, permanent means an indefinite period of more than one month.

Prescriptions for enteral feedings must be for an average of at least 750 calories per day over the prescribed period and must constitute at least 70 percent of the daily caloric intake to be considered for coverage by Medicaid. Coverage of prescribed feedings of less than an average of 750 calories per day may only be considered with additional physician documentation and justification of the reason for prescribing less than an average of 750 calories per day. Baby food and other regular grocery products than can be used with an enteral system are not covered.

All requests must include the following information:

- Name of the nutrient product or nutrient category; and
- Number of calories prescribed by enteral feeding per day (100 calories equals one unit) and whether the prescribed amount constitutes 70 percent or more of the daily caloric intake; and
- Frequency of administration per day; and
- Method of administration (oral or, if tube, whether syringe, gravity, or pump fed); and
- Route of administration, if tube fed (i.e., nasogastric, jejunostomy, gastrostomy, percutaneous enteral gastrostomy, or naso-intestinal tube); and
- Reason for use of a pump, if prescribed

Enteral nutritional therapy will not be approved for temporary impairments or for convenience feeding via gastrostomy.

Enteral feedings can only be provided for the most economic package equivalent in calories and ingredient content to the needs of the beneficiary as established by medical documentation. The physician(s) must document the reason for prescribing a formula including beneficiary's diagnoses.

Approved requests shall be reviewed at periodic intervals not to exceed six months. Approval may be granted for up to six months at a time. Medicaid, however, will pay for no more than one month's supply of enteral nutrients at any one time.

## Enteral Formula Coverage for Beneficiaries With Inborn Errors of Metabolism

This policy applies to beneficiaries with known or suspected inborn errors of metabolism served by the Office of Public Health (OPH) Genetic Disease program.

Louisiana Medicaid covers and considers medically necessary enteral formulas for beneficiaries of all ages without PA when the beneficiary has a diagnosis of an inborn error of metabolism made by a physician board certified in medical genetics or an advanced practice registered nurse collaborating with, or a physician assistant supervised by, a physician board certified in medical genetics.

Enteral formulas are also covered and considered medically necessary without PA if a beneficiary is suspected of having an inborn error of metabolism, pending the results of a definitive evaluation, when such enteral formula is needed to prevent morbidity. In this case, the enteral formula does not need to be ordered by a specialist. To provide documentation of medical necessity, the Genetic Disease program must maintain a completed Request for Enteral Formula for Inborn Errors of Metabolism order form in the beneficiary's record which is signed and dated by the appropriate ordering provider. Claims for enteral formula are subject to post-payment review and non-compliance with this policy may result in recoupment of overpayments.

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
B4100	Food thickener, administered orally, per oz
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)
B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
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
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

HCPCS Code	Description
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
<b>Metabolic and Specialized Foods</b>	
*S9432	Medical foods for noninborn errors of metabolism
*S9433	Medical food nutritionally complete, administered orally, providing 100% of nutritional intake
*S9434	Modified solid food supplements for inborn errors of metabolism
*S9435	Medical foods for inborn errors of metabolism

Codes labeled with an asterisk (\*) are not on the State of Louisiana Medicaid Fee Schedule and therefore may not be covered by the State of Louisiana Medicaid Program.

## U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

A medical food, as defined in section 5(b)(3) of the Orphan Drug Act [21 U.S.C. 360ee(b)(3)], is “a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.” Medical foods are not drugs and, therefore, are not subject to any regulatory requirements that specifically apply to drugs. However, manufacturers of medical foods must comply with all applicable FDA requirements for foods. For additional information, refer to the following guidance document: <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/guidance-industry-frequently-asked-questions-about-medical-foods-third-edition>. (Accessed January 3, 2024)

## References

Louisiana Department of Health Durable Medical Equipment Provider Manual. Chapter Eighteen of the Medicaid Services Manual. Section 18.2.11: Enteral Nutrition.  
<https://www.lamedicaid.com/provweb1/Providermanuals/manuals/DME/DME.pdf>. Accessed February 26, 2024.

## Policy History/Revision Information

Date	Summary of Changes
09/01/2024	<p><b>Application</b></p> <ul style="list-style-type: none"> <li>Added language to clarify <i>portions of the Coverage Rationale</i> contained in this policy represents Louisiana Medicaid coverage policy and are set forth [in the policy] in accordance with State requirements</li> </ul> <p><b>Coverage Rationale</b></p> <ul style="list-style-type: none"> <li>Revised language to indicate:           <ul style="list-style-type: none"> <li><b>Enteral Nutrition</b> <ul style="list-style-type: none"> <li>Enteral therapy or oral nutritional supplements may be provided safely and effectively in the home by non-professional persons who have undergone special training; Medicaid will not pay for any services furnished by non-physician professionals</li> <li>Enteral nutritional therapy is considered reasonable and necessary when medical documentation, such as hospital records and clinical findings, support an independent conclusion the beneficiary has a permanently inoperative internal body organ or function which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the beneficiary's general condition               <ul style="list-style-type: none"> <li>For purposes of this policy, "permanent" means an indefinite period of more than one month</li> </ul> </li> <li>Prescriptions for enteral feedings must be for an average of at least 750 calories per day over the prescribed period and must constitute at least 70 percent of the daily caloric intake to be considered for coverage by Medicaid               <ul style="list-style-type: none"> <li>Coverage of prescribed feedings of less than an average of 750 calories per day may only be considered with additional physician documentation and justification of the reason for prescribing less than an average of 750 calories per day</li> <li>Baby food and other regular grocery products than can be used with an enteral system are not covered</li> </ul> </li> <li>All requests must include the following information:               <ul style="list-style-type: none"> <li>Name of the nutrient product or nutrient category</li> <li>Number of calories prescribed by enteral feeding per day (100 calories equals one unit) and whether the prescribed amount constitutes 70 percent or more of the daily caloric intake</li> <li>Frequency of administration per day</li> <li>Method of administration (oral or, if tube, whether syringe, gravity, or pump fed)</li> <li>Route of administration, if tube fed (i.e., nasogastric, jejunostomy, gastrostomy, percutaneous enteral gastrostomy, or naso-intestinal tube)</li> <li>Reason for use of a pump, if prescribed</li> </ul> </li> <li>Enteral nutritional therapy will not be approved for temporary impairments or for convenience feeding via gastrostomy</li> <li>Enteral feedings can only be provided for the most economic package equivalent in calories and ingredient content to the needs of the beneficiary as established by medical documentation; the physician(s) must document the reason for prescribing a formula including beneficiary's diagnoses</li> <li>Approved requests shall be reviewed at periodic intervals not to exceed six months               <ul style="list-style-type: none"> <li>Approval may be granted for up to six months at a time</li> <li>Medicaid, however, will pay for no more than one month's supply of enteral nutrients at any one time</li> </ul> </li> </ul> </li> <li><b>Enteral Formula Coverage for Beneficiaries with Inborn Errors of Metabolism</b> <ul style="list-style-type: none"> <li>This policy applies to beneficiaries with known or suspected inborn errors of metabolism served by the <i>Office of Public Health (OPH) Genetic Disease</i> program</li> <li>Louisiana Medicaid covers and considers medically necessary enteral formulas for beneficiaries of all ages without prior authorization (PA) when the beneficiary has a diagnosis of an inborn error of metabolism made by a physician board certified in medical genetics or an advanced practice registered nurse collaborating with, or a physician assistant supervised by, a physician board certified in medical genetics</li> <li>Enteral formulas are also covered and considered medically necessary without PA if a beneficiary is suspected of having an inborn error of metabolism, pending the results of a definitive evaluation, when such enteral formula is needed to prevent morbidity</li> </ul> </li> </ul> </li> </ul>

Date	Summary of Changes
	<ul style="list-style-type: none"> <li>▪ In this case, the enteral formula does not need to be ordered by a specialist</li> <li>▪ To provide documentation of medical necessity, the <i>Genetic Disease</i> program must maintain a completed <i>Request for Enteral Formula for Inborn Errors of Metabolism</i> order form in the beneficiary's record which is signed and dated by the appropriate ordering provider</li> <li>▪ Claims for enteral formula are subject to post-payment review and non-compliance with this policy may result in recoupment of overpayments</li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>• Updated <i>References</i> section to reflect the most current information</li> <li>• Removed <i>Definitions</i>, <i>Description of Services</i>, <i>Benefit Considerations</i>, and <i>Clinical Evidence</i> sections</li> <li>• Archived previous policy version CS136LA.K</li> </ul>

## Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual<sup>®</sup> criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.