I. Description

Enteral nutrition (EN) is the provision of nutrition through a tube into the stomach or small intestine. EN is used for patients with an accessible and functioning gastrointestinal (GI) tract who have disorders of the pharynx, esophagus or stomach that prevent nutrients from reaching the absorbing surfaces in the small intestine. It may also be used for patients who have a disease of the small bowel that impairs the digestion and absorption of an oral diet.

EN involves administering nutritional requirements in liquid form directly into the GI tract through a syringe or a nasogastric, nasoduodenal, gastrostomy, or jejunostomy tube using gravity, or by using an infusion pump. The type of feeding tube used depends on the physiology of the GI tract, risk of aspiration, anticipated length of therapy, and placement procedure.

Feedings may be either intermittent or continuous (24 hours/day).

Generally for adults, a daily caloric intake of 2,000 - 2,200 calories is sufficient to maintain body weight. The administration of 750 calories per day or less is considered supplemental nutrition in adults.

II. Criteria/Limitations

A. Home enteral nutrition therapy is covered (subject to Limitations/Exclusions and Administrative Guidelines) when the following criteria are met:

1. The patient has one of the following indications:
   a. A long-term dysfunction or disease of structures that normally permit food to reach the small intestine for absorption. The condition may be anatomic or may be caused by a motility disorder, for example:
i. An anatomical inability to swallow due to dysfunction, disease, or obstruction of the esophagus or stomach (e.g., severe dysphagia, stricture, malignant neoplasm or resection).

ii. Central nervous system disease leading to interference with neuromuscular coordination of chewing and swallowing that results in risk of aspiration and malnutrition (e.g., cerebral or cerebellar infarction/hemorrhage, multiple sclerosis, coma, dementia, brain tumor, or AIDS), or

b. A disease of the small bowel that impairs digestion and absorption of an oral diet (e.g., Crohn’s disease) and

2. The patient's medical condition requires EN to maintain weight and strength commensurate with the patient's overall health status.

3. The expected duration of therapy is one week or longer.

B. Continuation of therapy is covered (subject to Limitations/Exclusions and Administrative Guidelines) when the patient's condition has not resolved or improved to the extent that the patient is able to tolerate adequate oral nutrition.

C. The patient does not have to meet the definition of homebound (as referenced in the Glossary) to receive this service.

III. Limitations/Exclusions

A. The following are not covered for home enteral nutrition therapy:

1. Increase protein or caloric intake in addition to the patient's daily diet.
2. Routine pre- and/or postoperative care.
3. Orally administered enteral nutrition products.
4. Regular food products that are administered via the feeding tube.

B. Therapy is not covered when:

1. The patient is able to tolerate adequate oral nutrition.
2. The patient or caregiver is unwilling or unable to manage or continue with the home infusion program.
3. The patient or caregiver is not compliant with treatment.
4. Follow-up assessment of the patient's clinical progress is not performed.
5. An adult patient is receiving 750 calories per day or less.
6. Surgery (e.g., esophageal dilation of stricture or resection of tumor) is delayed solely in favor of enteral nutrition.
7. Hospitalization is necessary due to the development of acute medical conditions and/or increasing risks of complications.

IV. Administrative Guidelines

A. Precertification is not required. HMSA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria.

B. The following must be documented in the patient's medical record and available upon request:
1. Physician's orders/prescription for enteral nutrition including the formulation, frequency, route of administration, and duration including start and end dates.
2. The expected duration of EN is one week or longer and the patient requires EN to maintain weight and strength commensurate with his/her overall health status.
3. A current nutritional care plan, including but not limited to, patient specific nutritional goals, duration of treatment, intensity and frequency of monitoring, and patient education.
4. Patient progress and satisfactory response to EN therapy (e.g., weight gain/maintenance, stable vital signs, functional status and performance, no signs and symptoms of intolerance to therapy).
5. Reassessment of the patient's condition and need for continued EN therapy to maintain nutritional requirements. Examples include one or more of the following:
   a. Clinical or radiological evidence demonstrating the inability to swallow.
   b. Evidence of an untreatable permanent dysfunction, disease, or obstruction of the esophagus or stomach.
   c. Permanent dysfunction of the central nervous system resulting in the inability to chew or swallow effectively with potential risk of aspiration.

C. For billing instructions, examples and code information, see Home Enteral Nutrition Therapy - Administrative Information.

V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

VI. References

