I. Description

Enteral nutrition is the provision of nutrition through a tube into the stomach or small intestine. It 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.

Enteral nutrition involves administering nutritional requirements in liquid form directly into the GI tract through 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/Guidelines

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

1. The patient has one of the following conditions:
   a. An anatomical abnormality or motility disorder that prevents food from reaching the small bowel.
   b. A central nervous system or neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition.
   c. A disease of the small bowel that impairs absorption of an oral diet.
2. The patient's medical condition requires enteral nutrition to maintain weight and strength commensurate with the patient's overall health status and the solution being administered is the primary source of nutrition (i.e. 60% or more of caloric nutritional intake).
3. The expected duration of therapy is one week or longer.

B. Continuation of therapy is covered (subject to Limitations 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

A. The following are not covered for home enteral nutrition therapy:
   1. Increase protein or caloric intake in addition to the patient's daily oral diet.
      2. Orally administered enteral nutrition products, except for inborn errors of metabolism.
      3. Regular food products that are administered via a feeding tube.

B. Therapy is not covered when:
   1. The patient is able to tolerate adequate oral nutrition.
   2. The patient or caregiver is not compliant with treatment.
   3. Follow-up assessment of the patient's clinical progress is not performed.
   4. An adult patient is receiving 750 calories or less of enteral nutrition per day.

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 enteral nutrition is one week or longer and the patient requires enteral nutrition 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 enteral nutrition 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 enteral nutrition 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
