MEDICAL POLICY STATEMENT
Nevada Marketplace

Policy Name & Number	Date Effective
Nutritional Supports-NV MP-MM-1761	09/01/2026
Policy Type	
MEDICAL	

Medical Policy Statements are developed from a review of the available evidence-based, clinical information based on and supported by clinical guidelines from medical specialties, peer-reviewed medical and scientific studies, nationally recognized utilization and technology assessment guidelines, and other medical management industry standards to aid in determining the medical necessity of a service. Medically necessary services are defined in the plan-specific Evidence of Coverage, Member Handbooks, Provider Manuals, Medical Policy Statements, and/or other plan policies and procedures.

Medical Policy Statements do not guarantee an authorization or payment of services. Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Medical Policy Statement and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document. Reasonable discretion may be used in interpreting and applying this Policy Statement to services provided in a particular case, and the policy may be modified at any time. Medical Policy Statements may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject
Nutritional Supports

B. Background
Enteral nutrition may be necessary to maintain optimal health status for members with diseases or structural defects of the gastrointestinal (GI) tract that interfere with transport, digestion, or absorption of nutrients. Such conditions may include anatomic obstructions due to cancer motility disorders, such as gastroparesis, or metabolic absorptive disorders such as phenylketonuria (PKU). Considerations are given to medical condition, nutrition and physical assessment, metabolic abnormalities, gastrointestinal function, and expected outcome. Enteral nutrition may be prescribed to serve as a member's primary source of nutrition (ie, total enteral nutrition) or as a supplement to an ordinary diet (ie, supplemental enteral nutrition). Enteral nutrition may be delivered through oral intake or through a tube into the stomach or small intestine.

RELiZORB® is a prescription device that is used to break down fats in enteral formulas from triglycerides into fatty acids and monoglycerides to allow absorption and utilization in the body. This process mimics the function of the enzyme lipase in the intestine of members with pancreatic insufficiency. The product is designed to fit in series with currently used enteral feeding circuits.

Breastfeeding is recommended by healthcare professionals and the U.S. Department of Health and Human Services. Research shows that breastfeeding provides health benefits for both the mother and the child. In some situations, parents may look for alternative sources of human breast milk for infants. Donor milk banks take voluntary steps to screen milk donors and safely collect, process, handle, test, and store human breast milk.

C. Definitions
- **Chronological Age** – The time elapsed after birth, usually described in days, weeks, months, and/or years.
- **Corrected Age** – A term most appropriately used to describe children up to 3 years of age who were born preterm or before gestational age of 37 weeks. This term represents the age of the child from the expected date of delivery (mother's due date). Corrected age is calculated by subtracting the number of weeks born before 40 weeks of gestation from the chronological age.
- **Donor Human Milk** – Breast milk that is expressed by a mother and processed by a human milk bank for use by a recipient that is not the donor mother's own infant.
- **Enteral Nutrition** – Nutritional support given via the gastrointestinal (GI) tract, either directly or through any of a variety of tubes used in specific medical conditions. This includes oral feeding as well as feeding using tubes, such as orogastric, nasogastric, gastrostomy, and jejunostomy tubes.
    - **Supplemental Nutrition** – The minority of daily calories are supplied by enteral nutrition products.

  - **Total Enteral Nutrition (TEN)** – The majority of daily calories are supplied by enteral nutrition products.
- **Human Milk Bank** – A service which recruits human breast milk donors, collects, pasteurizes, and stores donor human milk, tests the donor milk for bacterial contamination, and distributes donor human milk to recipient infants in need.
- **Inborn Errors of Metabolism (IEM)** – Inherited biochemical disorders resulting in enzyme defects that interfere with normal metabolism of protein, fat, or carbohydrate.
- **Malnutrition** – Deficiencies, excesses, or imbalances in an individual's intake of energy and/or nutrients, measured by *z*-scores, which are statistical measurements of standard deviation from WHO and CDC growth charts, calculated from weight for length or BMI by age.
  - **Mild Malnutrition** – *z* score equals -1 to -1.9 or *z* score decrease of 1 over time.
  - **Moderate Malnutrition** – *z* score equals -2 to -2.9 or *z* score decrease of 2 over time.
  - **Severe Malnutrition** – *z* score equals -3 or less or *z* score decrease of 3 over time.
- **Medical Food** – Specially formulated and processed for individuals who are seriously ill or who require the product as a major treatment modality. This term does not pertain to all foods fed to ill individuals. Medical foods are intended solely to meet the nutritional needs of individuals who have specific metabolic or physiological limitations restricting their ability to digest regular food. This can include specially formulated infant formulas. According to the Food and Drug Administrations (FDA), a product must meet all the following minimum criteria to be considered a medical food:
  - The product must be a food for oral or tube feeding.
  - The product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements.
  - The product must be used under the supervision of a physician.
- **Oral Nutrition (Oral Feeding)** – Nutritional support given via the oral route.
- **Ordinarily Prepared Food** – Regular grocery products including typical, not specially formulated, infant formulas.
- **RELiZORB®** – An FDA-approved digestive enzyme cartridge indicated for use in pediatric patients (including neonates and infants) and adult patients to treat exocrine pancreatic insufficiency.
- **Therapeutic Oral Non-Medical Nutrition:**
  - **Food Modification** – Some conditions may require adjustment of carbohydrate, fat, protein, and micronutrient intake or avoidance of specific allergens (eg, diabetes mellitus, celiac disease).
  - **Fortified Food** – Food products with additives to increase energy or nutrient density.
  - **Functional Food** – Food that is fortified to produce specific beneficial health effects.

- **Texture Modified Food and Thickened Fluids** – Liquidized/thin puree, thick puree, finely minces, or modified normal.
- **Modified Normal** – Eating normal foods by avoiding particulate foods that are a choking hazard.

D. Policy

I. **Oral Nutrition**

A. Oral nutrition requests for members with inborn errors of metabolism meet medical necessity criteria and do not require further review when the product is specifically formulated for the member's condition.

B. **Total oral nutrition** is considered medically necessary when **ALL** the following criteria are met:

1. The product is a medical food for oral feeding.
2. The product is used under medical supervision.
3. The member has the ability to swallow without increased risk of aspiration.
4. The product is the member's primary source of nutrition.
5. The product is labeled and used for nutritional management of a member's specific medical condition without which serious morbidities (physical or mental) may develop, **OR** the product is used to promote normal development or function for the member.
6. The product is used under the supervision of a physician, physician's assistant, or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments.
7. The member has **one** of the following medical conditions:
   a. A condition caused by an inborn error of metabolism, including, but not limited to
      - phenylketonuria
      - homocystinuria
      - methylmalonic academia
      - galactosemia
   b. A condition that interferes with nutrient absorption and digestion, including, but not limited to
      01. current diagnosis of non-IgE-mediated cow's milk allergy (CMA) as defined by any of the following:
          (1). abnormal stools, defined as hemoccult positive, mucous-containing, foam-containing, or diarrhea
          (2). poor weight gain trajectory for age (eg, malnutrition)
          (3). atopic dermatitis: age of onset less than 3 months, severe eczema, exacerbation of eczema noted with introduction of cow's milk, cow's milk formula, or maternal ingestion of cow's milk if breastfed
      02. allergy to specific foods, including food-induced anaphylaxis, or severe food allergy indicating a sensitivity to intact protein product, as diagnosed through a formal food challenge

03. allergic eosinophilic enteritis (colitis/proctitis, esophagitis, gastroenteritis)
04. cystic fibrosis with malabsorption
05. diarrhea or vomiting resulting in clinically significant dehydration requiring treatment by a medical provider
06. malabsorption unresponsive to standard age-appropriate interventions when associated with failure to gain weight or meet established growth expectations
07. malnutrition (as defined by Nelson's Textbook of Pediatrics and not iatrogenically- or medication-induced, formerly failure to thrive) that is moderate to severe and unresponsive to standard age-appropriate interventions (eg, commercial shakes, protein bars) when associated with weight loss, failure to gain weight, or to meet established growth expectations, including but not limited to:
    (1). premature infants who have not achieved the 25th percentile for weight based on their corrected gestational age
    (2). individuals with end-stage renal disease and hypoalbuminemia (albumin less than 4gm/dl)

8. Approval duration can be up to 12 months for all oral nutrition products.

C. **Supplemental oral nutrition** is considered medically necessary when **ALL** the following apply:
1. The product is being used to supplement the member's primary source of nutrition.
2. The product is used as part of a defined and limited plan of care (eg, member transitioning from total enteral nutrition to standard diet for age, member undergoing cancer treatment).
3. Documentation of a medical basis for the member's inability to maintain appropriate body weight and nutritional status (initial and ongoing) with normal or therapeutic oral nutrition. For example, malnutrition that is moderate to severe and unresponsive to standard age-appropriate interventions.
4. There is documentation of ongoing evidence of member's positive response to the oral nutrition. For example, individuals who have improved from moderate to severe malnutrition to mild malnutrition or normal health status may require documentation/evidence indicating that without the supplementation there is a risk of decline in nutritional status.
5. The product must be used under the supervision of a physician, physician's assistant, or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments.
6. The primary reason is not for convenience of the member or caregiver.
7. All avenues of coverage available must be exhausted first. For example, members eligible for their county Women, Infant, and Children (WIC) program must apply for an eligibility evaluation before supplemental nutrition coverage will be considered.

8. Approval duration can be up to 12 months for all supplemental oral nutrition products.

II. **Enteral Nutrition via Tube**:
   A. Enteral nutrition requests for members with inborn errors of metabolism and/or low-profile gastrostomy/jejunostomy/gastrojejunostomy tubes (eg, Mic-Key, button) meet medical necessity criteria and do not require further review.
   B. **Total enteral nutrition via tube feeding** is considered medically necessary when the member has a functioning, accessible gastrointestinal tract, and **ALL** the following:
      1. Enteral nutrition comprises the majority of the member's diet.
      2. The product is used under the supervision of a physician, physician's assistant, or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments.
      3. There is documentation that the member cannot ingest nutrients orally due to a medical condition (physical or mental) which meets any of the following:
         a. interferes with swallowing (eg, dysphagia from a neurological condition, severe chronic anorexia nervosa or serious cases of oral aversion in children, which render the member unable to maintain weight and nutritional status with oral nutrition alone)
         b. puts the member at risk for aspiration if nutrition is given by oral route
         c. is associated with anatomical abnormality of the proximal GI tract (eg, tumor of the esophagus causing obstruction)
      4. Approval duration can be up to 12 months for all enteral nutrition products.
   C. **Supplemental enteral nutrition via tube** is considered medically necessary when **ALL** the following criteria are met:
      1. The product makes up the minority of the member's daily intake (ie, supplement to member's primary source of nutrition).
      2. The enteral product is used as part of a defined and limited plan of care (eg, member transitioning from total enteral nutrition to standard diet for age, member undergoing treatment for cancer).
      3. There is documentation of a medical basis for the inability of the member to maintain appropriate body weight and nutritional status (initial and ongoing) with normal or therapeutic enteral nutrition. For example, malnutrition that is moderate to severe and unresponsive to standard age-appropriate interventions.
      4. There is documentation of ongoing evidence of member's positive response to the enteral nutrition. For example, individuals who have improved from moderate to severe malnutrition to mild malnutrition or normal health status may require documentation/evidence indicating that without the supplementation there is a risk of decline in nutritional status.
      5. The product must be used under the supervision of a physician, physician's assistant, or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments.
      6. The primary reason is not for convenience of the member or caregiver.

7. All avenues of coverage available must be exhausted first (eg, members eligible for their county Women, Infant, and Children (WIC) program must apply for an eligibility evaluation before supplemental nutrition coverage will be considered).
8. Approval duration can be up to 12 months for all supplemental enteral nutrition products.

III. **Donor human milk**
   A. CareSource considers human milk medically necessary when **ALL** the following criteria are met:
      1. The provider is in good standing with the Human Milk Banking Association of North America.
      2. Documentation supports medical necessity with at least one of the following:
         a. The infant has a congenital or acquired condition that places the infant at high risk of developing necrotizing enterocolitis.
         b. The infant has a documented birth weight of ≤ 1500 grams or gestational age ≤ 32 weeks.
      3. For donor breast milk use outside the hospital, documentation must include why elemental formula cannot be used to meet the infant's needs.
      4. Documentation supports that the provider has attested to educating the member in the donation process and about human milk.
      5. Documentation supports that the provider discussed the risks and benefits with the member.
   B. Per the Food & Drug Administration, only human milk banks that screen milk donors and take precautions to ensure the safety of its milk should be utilized.
   C. Approval duration is 3 months.

IV. The Plan provides Benefits for 100% human diet, if the 100% human diet and supplemented milk fortifier products are prescribed for the prevention of necrotizing enterocolitis and associated co-morbidities and administered under the direction of a physician. 100% human diet means the supplementation of a mother's expressed breast milk or donor milk with a milk fortifier.

V. CareSource does **NOT** consider the following medically necessary:
   A. nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist, unless administered through a pre-existing feeding tube
   B. use of a nutritional product for the convenience, preference, or lifestyle/social consideration of the member or caregiver
   C. therapeutic diets where non-medical foods are tolerated, including any of the following:
      1. food modification
      2. texture modified food
      3. thickened fluids
      4. fortified food

5. functional food
6. modified normal
7. flavorings

D. Relizorb® (insufficient published evidence)
E. oral nutrition products for meal replacements or snack alternatives
F. feeding tubes for individuals with advanced dementia
G. products administered in an outpatient provider setting, which are not separately reimbursable

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	07/16/2025	New market, approved at Committee.
Date Revised	05/20/2026	Review: updated FDA language on Relizorb, clarified lifestyle/social limitation, added documentation requirements and approval time frame for donor milk, updated references, approved at Committee.
Date Effective	09/01/2026	
Date Archived		

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