MEDICAL POLICY STATEMENT

GEORGIA MEDICAID

Policy Name	Policy Number	Effective Date
Nutritional Supplements	MM-0759	05/01/2020-06/30/2021

Policy Type			
MEDICAL	Administrative	Pharmacy	Reimbursement

Medical Policy Statement prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

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A. Subject

Nutritional Supplements

B. Background

Nutrition may be delivered through a tube into the stomach or small intestine. Enteral Nutrition may be medically necessary for dietary management to provide sufficient caloric and nutrition needs as a result of limited or impaired ability to ingest, digest, absorb or metabolize nutrients; or for a special medically determined nutrient requirement. Considerations are given to medical condition, nutrition and physical assessment, metabolic abnormalities, gastrointestinal function, and expected outcome. Enteral nutrition may be either for total enteral nutrition or for supplemental enteral nutrition.

This policy includes nutrition that is for medical purposes only.

C. Definitions

- **Enteral Nutrition**– Nutrition delivered through an enteral access device into the gastrointestinal tract bypassing the oral cavity.
- **Medical Food** – Food specially formulated and processed to be consumed or administered by oral intake or enteral access device. The intent is to meet distinctive nutritional requirements of a disease or condition when dietary management cannot be met by modifying a normal diet.
- **Enteral Access Device** – A tube or stoma is placed directly into the gastrointestinal tract for the delivery of nutrients.
- **Inborn Errors Of Metabolism (IEM)** – Inherited biochemical disorders resulting in enzyme defects that interfere with normal metabolism of protein, fat, or carbohydrate.
- **Therapeutic oral non-medical nutrition**:
  - **Food Modification –** Some conditions may require adjustment of carbohydrate, fat, protein, and micronutrient intake or avoidance of specific allergens. i.e. diabetes mellitus, celiac disease
  - **Fortified Food –** Food products that have 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 minced or modified normal.
  - **Modified Normal –** Eating normal foods, but avoiding particulate foods that are a choking hazard.

D. Policy

I. Oral Medical Foods
   A. Prior Authorization is required.
   B. CareSource considers oral medical foods medically necessary when the following criteria are met:
      1. Must be a medical food for oral feeding **AND**

2. The product must be ordered and supervised by a health care provider authorized to prescribe dietary treatments **AND**
3. Member has the ability to swallow without increased risk of aspiration **AND**
4. Documentation supports **ALL** of the following criteria:
    a. Medical food consists of more than 50% of intake
    b. Member is unable to maintain body weight and nutritional status (initial and ongoing treatment) with regular or therapeutic oral nutrition **AND**
        01. Member has Inborn error of metabolism or genetic disorder including but not limited to
            (1) Phenylketonuria (PKU)
            (2) Homocystinuria
            (3) Methylmalonic acidemia

C. CareSource does NOT consider the following medically necessary:
1. Therapeutic diets where non-medical foods are tolerated
    a. Food modification
    b. Texture modified food and thickened fluids
    c. Fortified Food
    d. Functional Food
    e. Modified normal
    f. Flavorings
2. Products for meal replacements or snack alternatives.
3. When use of product is for convenience or preference of member/caregiver.

II. Enteral Nutrition
A. Prior authorization is required for enteral nutrition
1. A Georgia Department of Community Health certificate of medical necessity or prescription is required with each PA request
2. PAs are required initially for 3 months, then at 6 month and 1 year intervals.
3. Requests following the 3 month approval must include the following documentation:
    a. Progress of member
        01. Growth and Development AND
        02. Height and Weight AND
        03. Weaning steps taken OR due to condition, member will always use enteral nutrition.

B. Prior authorization is not required for enteral supplies (except for B9988 with U1 modifier), however the following documentation must be submitted with the claim
1. Per the Georgia Policies and Procedures for Durable Medical Equipment Services, a face to face visit with prescribing provider must occur during the following occurrences:
    a. Within 6 months of the start date of the initial written order.
    b. Within 6 months of a re-order of equipment or supplies
    c. When a supplier is changed
    d. When base equipment is replaced
2. Documentation from the face to face visit must support medical necessity for items ordered.

C. An enteral nutrition orders must include **ALL** of the following:

1. Item or supply
2. Number of calories per day
3. Length of need
4. If applicable,
   a. Frequency of use with amounts to be dispensed
   b. Route of administration
   c. Number of refills (approved months/units)
5. Quantity to be dispensed
6. Date of order or start date if different
7. Signature of medical provider

D. A new prescription and written order must be completed when
   1. Change in supplier
   2. Change in frequency, item, or amount prescribed
   3. Change in length or established length of need expires
   4. Change in member condition
   5. Replacement of item when item is worn or has exceeded reasonable useful lifetime

E. CareSource considers enteral nutrition medically necessary when ALL of the following criteria are met:
   1. Under the age of 21 **AND**
   2. Must be a specialized enteral formula ordered by a physician **AND**
   3. Must be used under medical supervision **AND**
   4. Member has an enteral access device **AND**
   5. Member is not able to consume nutrients orally **AND**
   6. Member has at least one of the following:
      a. Condition that impairs the ability to ingest enough calories and nutrients or restricts calorie and nutrients in from reaching the gastrointestinal tract **OR**
      b. Condition of small bowel impairing digestion and absorption of an oral diet which requires enteral feedings to provide sufficient nutrients to maintain weight and strength **OR**
      c. Inborn Error of Metabolism

      AND
   7. Documentation supports all of the following criteria:
      a. Enteral nutrition is the primary source of nutrition (greater than 50%) **AND**
      b. Member or caregiver is able and willing to administer enteral feeding **AND**
      c. All avenues of coverage available must be exhausted first i.e. WIC funding

F. CareSource does NOT consider the following medically necessary:
   1. Advanced dementia (Feeding tubes are not recommended by American Geriatrics Society)
   2. In-line cartridge containing digestive enzymes such as Relizorb (Insufficient published evidence).
   3. Products administered in an outpatient provider setting are not separately reimbursable.
   4. When use of product is for convenience or preference of member/caregiver.

NOTE: CareSource does NOT consider a routine or ordinary diet medically necessary.

E. Conditions of Coverage
F. Related Polices/Rules
G. Review/Revision History

	DATE	ACTION
Date Issued	05/01/2020	
Date Revised		
Date Effective	05/01/2020	New policy
Date Archived	06/30/2021	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. American Geriatric Society Committee and clinical Practice and Models of Care Committee. (2014). American Geriatrics Society feeding Tubes in Advanced Dementia position Statement. *Journal of the American Geriatrics Society,* 62 (8), 1590-1593. DOI: 10.1111/jgs.12924.
2. Cederholm, T., Barazzoni, R., Austin, P., Ballmer, P., Biolo, G., Bischoff, S., … Singer, P. (2017). ESPEN guidelines on definitions and terminology of clinical nutrition. *Clinical Nutrition*, *36*(1), 49-64. doi:10.1016/j.clnu.2016.09.004.
3. Georgia Department of Community Health. (2019). Part II Policies and Procedures for Durable Medical Equipment Services. Retrieved on 4/4/2019 from https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/Durable%20Medical%20Equipment%20Services%2020190401195108.pdf
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The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.

GA-P-0832 Date Issued 05/01/2020 DCH Approved 1/28/2020