Enteral Feeding and Intradialytic Parenteral Nutrition, Medical 13

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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.

Description & Definitions:

Enteral feeding refers to the delivery of liquid feedings through a tube into the stomach or small intestine. It is sometimes called a tube feeding.

Intradialytic Parenteral Nutrition (IDPN) is a method of delivering nutrition to individual's undergoing hemodialysis.

Medical Food means "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", as described by the FDA.

* Medically necessary formula and enteral nutrition products means "any liquid or solid formulation of formula and enteral nutrition products for covered individuals requiring treatment for an inherited metabolic disorder (an inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, or fatty acids) and for which the covered individual's physician has issued a written order stating that the formula or enteral nutrition product is medically necessary and has been proven effective as a treatment regimen for the covered individual and that the formula or enteral nutrition product is a critical source of nutrition as certified by the physician by diagnosis. The medically necessary formula or enteral products do not need to be the covered individual's primary source of nutrition."

"Over-the-counter" (OTC) – medications and products you can buy without a prescription. (DMAS only considers Pediasure, Boost, and Ensure retail formulations as OTC)

Pancreatic enzyme replacement therapy (PERT) is a method to providing continuous in-line enzyme replacement.

Total Parenteral nutrition (TPN) nutritional substance by intravenous infusion to nourish individuals who are malnourished or may develop malnutrition and who are not candidates for enteral support.

RELZORB - In-line cartridge containing digestive enzyme(s) for enteral feeding

"Routine infant formula" - formulas intended for healthy, full-term infants.

"Specialty Formulas" - formulas intended for an infant who has an inborn error of metabolism, low birth weight, or who otherwise has a medical need and prescribed by a practitioner.

Criteria:

Nutritional feeding is considered medically necessary for **1 or more** of the following:

- Orally administered enteral nutrition may be authorized for 6 months when the nutritional supplement is specific to inherited metabolic disorders, such as PKU, etc. when **all of the following** are met:
  - Is necessary to treat a medical condition.
  - Not generally available in grocery stores, health food stores, or the retail section of a pharmacy
  - Not used as food by the general population
- Nasogastric or gastrostomy tube administered enteral nutrition may be authorized for 6 months when it is medically necessary to provide nutrition to the individual, to include related supplies, equipment, and nursing services as indicated by sufficient evidence.
- **Total Parenteral Nutrition (TPN)**, to include related supplies, equipment, and nursing services necessary to provide total parenteral nutrition will be authorized if the TPN is determined to be medically necessary as indicated by sufficient evidence of **one or more of the following**:
  - The individual has a medical condition which significantly impairs the absorption of nutrients through the gastrointestinal tract.
  - The individual has impaired motility of the stomach and/or gastrointestinal tract which causes an inability for nutrients to be absorbed .
- **Digestive enzyme cartridges (e.g. RelizorbTM)** is considered medically necessary when **ALL the following criteria are met:**
  - The individual is age 2-years or older.
  - The individual has a diagnosis of cystic-fibrosis.
  - The individual receives enteral nutrition trough a gastrostomy or naso-gastric tube.
  - The individual requires overnight enteral feeding to meet caloric and nutritional requirements.
  - The individual had a trial and failure of pancreatic enzyme replacement therapy as evidenced by **ALL of the following**:
    - Malnutrition
    - Poor growth
    - Gastrointestinal symptoms (bloating, cramping, gassiness, diarrhea, fatty stools, nausea, vomiting constipation, abdominal discomfort) which cause impairment or inability to tolerate enteral nutrition
  - Initial authorization of Relizorb will be for 3 months.
- **Further authorization of Digestive enzyme cartridges (e.g. RelizorbTM)** is considered medically necessary when A**LL the following criteria are met**:
  - Clinical records show a clear improvement in nutrition, growth, maintenance of body mass index, and/or gastrointestinal symptoms.

Enteral and Parenteral feeding, and Intradialytic Parenteral Nurtirion are considered **not medically necessary** for any use other than those indicated in clinical criteria as the current role remains uncertain, based on review of existing evidence, or are considered a convenience item, to include but not limited to:

- Baby food
- Banked breast milk for a nonhospitalized infant
- Intradialytic Parenteral Nutrition (IDPN)
- Intraperitoneal nutrition
- Intraperitoneal amino acids
- Items available in grocery stores, health food stores, or the retail section of a pharmacy
- KetoForce
- Nutritional supplements offered over the counter, including vitamins and minerals
- Oral food products, including but not limited to gluten free foods, nutritional puddings, protein bars, low carbohydrate foods, etc. (Including foods normally taken orally that are blended regardless if they are taken parenteral or enterally.)
- “Routine” Infant formula for children under one-year of age
- Specialized formula (e.g. lactose – free formula)

Document History:

Revised Dates:

- 2026: January – Implementation date of May 1, 2026. Coding and criteria updated to align with authorization changes. Parenteral nutrition criteria removed due to coding updated.
- 2025: No change to criteria. Updated to new policy format.
- 2024: January (tabled), February, March
- 2022: February
- 2021: January, May
- 2020: January, July, December
- 2016: March
- 2015: February, May
- 2014: March
- 2013: February, July
- 2012: February
- 2011: May
- 2010: September
- 2009: January
- 2008: March

Reviewed Dates:

- 2023: January
- 2018: November
- 2017: December
- 2007: December
- 2001: May
- 2000: September

Origination Date:

- March 1991

Coding:

Medically necessary with criteria:

Coding	Description
B4034	Enteral feeding supply kit; syringe fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape
B4035	Enteral feeding supply kit; pump fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape

B4036	Enteral feeding supply kit; gravity fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape
B4081	Nasogastric tubing with stylet
B4082	Nasogastric tubing without stylet
B4083	Stomach tube - Levine type
B4087	Gastrostomy/jejunostomy tube, standard, any material, any type, each
B4088	Gastrostomy/jejunostomy tube, low-profile, any material, any type, each
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)
B4105	In-line cartridge containing digestive enzyme(s) for enteral feeding, each
B4148	Enteral feeding supply kit; elastomeric control fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape
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
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
B9998	NOC for enteral supplies
B9999	NOC for parenteral supplies
S9341	Home therapy; enteral nutrition via gravity; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem
S9342	Home therapy; enteral nutrition via pump; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem
S9343	Home therapy; enteral nutrition via bolus; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem
S9364	Home infusion therapy, total parenteral nutrition (TPN); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem (do not use with home infusion codes S9365-S9368 using daily volume scales)
S9365	Home infusion therapy, total parenteral nutrition (TPN); 1 liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula, (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
S9366	Home infusion therapy, TPN, more than 1 liter but no more than 2 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
S9367	Home infusion therapy, total parenteral nutrition (TPN); more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
S9368	Home infusion therapy, total parenteral nutrition (TPN); more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device-code(s) does not constitute or imply member coverage or provider reimbursement.

Special Notes: *

- Coverage: See the appropriate benefit document for specific coverage determination. Individual specific benefits take precedence over medical policy.
- Application to products: Guidance is applicable to Sentara Health Plan Virginia Medicaid products.
- Authorization requirements: Pre-certification by the Plan is required.
- Special Notes:
    - Medicaid
        - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
        - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
        - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.

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Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Provider Manual Title: Durable Medical Equipment, Prosthetics, Orthotics and Supplies - Chapter IV: Covered Services and Limitations. (2025, Dec 05). Retrieved Jan 13, 2025, from Virginia Department of Medical Assistance Services: https://vamedicaid.dmas.virginia.gov/sites/default/files/2025-12/DME%20Chapter%20IV%20%28updated%2012.5.25%29_Final.pdf

Keywords:

Enteral and Parenteral Feeding, shp medical 13, tpn, total parenteral nutrition, formula, thickener, Intraperitoneal nutrition, amino acids, Intradialytic Parenteral Nutrition, foods, SHP Enteral and Parenteral Feeding and Intradialytic Parenteral Nutrition, KetoForce