

Medical Policy: Formula and Enteral Nutrition (Commercial - Connecticut Members)



POLICY NUMBER	LAST REVIEW DATE	APPROVED BY
M20190015-CT	6/12/2020	MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

Formula and Enteral Nutrition for Connecticut Members

Criteria:

- A. ENTERAL NUTRITION – TUBE FEEDING. MUST MEET ALL OF THE FOLLOWING:
 1. The enteral nutrition/formula is ordered by a physician.
 2. The enteral nutrition/formula is for total (100%) nutritional/caloric replacement.
 3. The individual has a medical illness or injury.

- B. ENTERAL NUTRITION – ORAL. MUST MEET ALL OF THE FOLLOWING:
 1. The enteral nutrition/formula is ordered by a physician.
 2. The enteral nutrition/formula is for total (100%) nutritional/caloric replacement.
 3. The individual has a gastrointestinal illness or injury preventing the normal absorption of nutrients.
 4. The ingredients of the enteral nutrition/formula are specifically modified for use in individuals whose gastrointestinal tracts cannot absorb nutrients normally. This does not include standard enteral formulas that can be used for individuals with normal GI tracts

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C. MODIFIED FOOD PRODUCTS FOR INHERITED METABOLIC DISEASES OR CONDITIONS (STATE OF CONNECTICUT MANDATE). MUST MEET ALL OF THE FOLLOWING:

1. The modified food product(s) is ordered by and administered under a physician's direction.
2. The modified food product(s) is for the dietary treatment of an inherited metabolic disease¹ such as:
 - a. Phenylketonuria
 - b. Maple syrup urine disease
 - c. Sickle cell disease
 - d. Hypothyroidism
 - e. Homocystinuria
 - f. Cystic fibrosis
 - g. Galactosemia
 - h. Biotinidase deficiency
 - i. Other inherited disorder of metabolism
 - j. Congenital adrenal hyperplasia

OR

3. The modified food is a low protein product;

OR

4. The modified food is an amino acid modified product.

D. OTHER SPECIALIZED INFANT FORMULAS (STATE OF CONNECTICUT MANDATE). MUST MEET ALL OF THE FOLLOWING:

"Specialized formula" means a nutritional formula for children up to age twelve that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific diseases.

1. The individual has not reached his/her 12th birthday.
2. The individual will use the specialized formula under the direct supervision of a physician.
3. The individual has a known, clearly diagnosed disease or condition that includes protein intolerance or problems with gastrointestinal absorption and that is reasonably expected to last at least 90 days. Such conditions do not include nonspecific feeding problems in otherwise healthy infants.
4. The ingredients of the specialized formula are specifically modified for use in individuals whose GI tracts cannot absorb nutrients normally. This would not include standard cow- milk or soy-based formulas since these formulas can be used by healthy infants and the formulas have not been modified to enhance absorption from an abnormal GI tract.

¹ As noted in Connecticut statute, "inherited metabolic disease" is defined as (A) a disease for which newborn screening is required under section 19a-55; and (B) cystic fibrosis.

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References

1. State of Connecticut Public Act No. 01-101, Senate Bill No. 524, June 2001; House Bill 5201, Oct 2004.
2. Conn State Mandate Sec. 38a-492c.
3. 2020 ConnectiCare Insurance Company, Inc. Membership Agreement

Revision history

DATE	REVISION
6/2020	Annual Review <ul style="list-style-type: none">• Changes effective date to last review date• Added in" ¹ as noted in Connecticut statute "(B) cystic fibrosis• Added in criteria section C#2 Congenital adrenal hyperplasia
5/2019	<ul style="list-style-type: none">• Reformatted and reorganized policy, transferred content to new template with new Medical Policy Number
03/10/04, 11/10/04, 04/13/05, 10/11/06, 11/07/07, 10/29/08, 10/14/09, 11/10/10, 11/09/11, 12/05/12, 12/31/13, 12/03/14, 12/09/15, 5/1/2019	