

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



POLICY NUMBER	LAST REVIEW DATE	APPROVED BY
M20190015-MA	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 MA 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 Massachusetts Members

(including non-prescription enteral formulas, food products and medical formulas)

Criteria:

- A. MALABSORPTION OR INHERITED DISEASE OF AMINO ACIDS OR ORGANIC ACIDS. MUST MEET ALL OF THE FOLLOWING:
 1. The enteral formula, food product and/or medical formula is ordered by a physician, nurse practitioner or physician’s assistant.
 2. The enteral formula, food product and/or medical formula is for the treatment of any of the following:
 - a. Crohn’s disease
 - b. Ulcerative colitis
 - c. Gastroesophageal reflux
 - d. Gastroesophageal motility
 - e. Chronic intestinal psuedo-obstruction
 - f. Phenylketinuria
 - g. Tyrosinemia
 - h. Homocystinuria
 - i. Maple syrup disease
 - j. Propionic acidemia

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- k. Methylmalonic acidemia in infants and children
- l. Other inherited disease of amino acids and organic acids
- m. To protect the unborn fetuses or pregnant women with phenylketonuria (PKU)

B. 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.

References

1. State of Massachusetts, M.G.L. c. 176G, § 4 and M.G.L. c. 175 § 47C Mandate on Non-Prescription Enteral Formulas, Food Products and Medical Formulas.

Revision history

DATE	REVISION
6/2020	Annual Review <ul style="list-style-type: none">• Changed effective date to last review date
5/2019	<ul style="list-style-type: none">• Reformatted and reorganized policy, transferred content to new template with new Medical Policy Number
11/10/04, 04/13/05, 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	