Home Enteral Nutrition Therapy

I. **Policy**

University Health Alliance (UHA) will reimburse for home enteral nutrition when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. **Criteria/Guidelines**

A. Home enteral nutrition (EN) therapy is covered (subject to Limitations/Exclusions and Administrative Guidelines) when the following criteria are met:

1. The patient has one of the following indications:
   a) A long-term dysfunction or disease of structures that normally permit food to reach the small intestine for absorption
      The condition may be anatomic or may be caused by a motility disorder, for example:
      i) An anatomical inability to swallow due to dysfunction, disease, or obstruction of the esophagus or stomach (e.g., severe dysphagia, stricture, malignant neoplasm or resection).
      ii) Central nervous system disease leading to interference with neuromuscular coordination of chewing and swallowing that results in risk of aspiration and malnutrition (e.g., cerebral or cerebellar infarction/hemorrhage, multiple sclerosis, coma, dementia, brain tumor, or AIDS), or
   b) A disease of the small bowel that impairs digestion and absorption of an oral diet (e.g., Crohn's disease) **and**

2. The patient’s medical condition requires enteral nutrition to maintain weight and strength commensurate with the patient’s overall health status

3. The expected duration of therapy is one week or longer

B. Continuation of therapy is covered (subject to Limitations/Exclusions and Administrative Guidelines) when the patient's condition has not resolved or improved to the extent that the patient is able to tolerate adequate oral nutrition.

C. The patient does not have to be homebound.

D. **NOTE:**

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members’ individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may
request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. Limitations/Exclusions

A. The following are not covered for home enteral nutrition therapy:

1. Increase protein or caloric intake in addition to the patient's daily diet
2. Routine pre- and/or postoperative care
3. Orally administered enteral nutrition products
4. Regular food products that are administered via the feeding tube

B. Therapy is not covered when:

1. The patient is able to tolerate adequate oral nutrition
2. The patient or caregiver is unwilling or unable to manage or continue with the home infusion program
3. The patient or caregiver is not compliant with treatment
4. Follow-up assessment of the patient's clinical progress is not performed
5. An adult patient is receiving 750 calories per day or less
6. Surgery (e.g., esophageal dilation of stricture or resection of tumor) is delayed solely in favor of enteral nutrition
7. Hospitalization is necessary due to the development of acute medical conditions and/or increasing risks of complications

IV. Administrative Guidelines

A. Prior authorization is not required.

B. UHA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination.

C. The following must be documented in the patient's medical record and available upon request:

1. Physician's orders/prescription for enteral nutrition including the formulation, frequency, route of administration, and duration including start and end dates
2. The expected duration of EN is one week or longer and the patient requires EN to maintain weight and strength commensurate with his/her overall health status
3. A current nutritional care plan, including but not limited to, patient specific nutritional goals, duration of treatment, intensity and frequency of monitoring, and patient education
4. Patient progress and satisfactory response to EN therapy (e.g., weight gain/maintenance, stable vital signs, functional status and performance, no signs and symptoms of intolerance to therapy)
5. Reassessment of the patient's condition and need for continued EN therapy to maintain nutritional requirements. Examples include one or more of the following:
   a. Clinical or radiological evidence demonstrating the inability to swallow
   b. Evidence of an untreatable permanent dysfunction, disease, or obstruction of the esophagus or stomach
c. Permanent dysfunction of the central nervous system resulting in the inability to chew or swallow effectively with potential risk of aspiration

V. Policy History

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