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**CHAPTER 18: DURABLE MEDICAL EQUIPMENT**

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**18.2.11 Enteral Nutrition**

Enteral therapy or oral nutritional supplements may be provided safely and effectively in the home by non-professional persons who have undergone special training. Medicaid will not pay for any services furnished by non-physician professionals.

Enteral nutritional therapy is considered reasonable and necessary when medical documentation, such as hospital records and clinical findings, support an independent conclusion the beneficiary has a permanently inoperative internal body organ or function which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the beneficiary's general condition. For purposes of this policy, permanent means an indefinite period of more than one month.

Prescriptions for enteral feedings must be for an average of at least 750 calories per day over the prescribed period and must constitute at least 70 percent of the daily caloric intake to be considered for coverage by Medicaid. Coverage of prescribed feedings of less than an average of 750 calories per day may only be considered with additional physician documentation and justification of the reason for prescribing less than an average of 750 calories per day. Baby food and other regular grocery products that can be used with an enteral system are not covered.

All requests must include the following information:

1. Name of the nutrient product or nutrient category;
2. Number of calories prescribed by enteral feeding per day (100 calories equals one unit) and whether the prescribed amount constitutes 70 percent or more of the daily caloric intake;
3. Frequency of administration per day;
4. Method of administration (oral or, if tube, whether syringe, gravity, or pump fed);
5. Route of administration, if tube fed (i.e., nasogastric, jejunostomy, gastrostomy, percutaneous enteral gastrostomy, or naso-intestinal tube); and
6. Reason for use of a pump, if prescribed.

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Enteral nutritional therapy will not be approved for temporary impairments or for convenience feeding via gastrostomy.

Enteral feedings can only be provided for the most economic package equivalent in calories and ingredient content to the needs of the beneficiary as established by medical documentation. The physician(s) must document the reason for prescribing a formula including beneficiary's diagnoses.

Approved requests shall be reviewed at periodic intervals not to exceed six months. Approval may be granted for up to six months at a time. Medicaid, however, will pay for no more than one month's supply of enteral nutrients at any one time.

**Enteral Infusion Pump**

A standard enteral infusion pump will be approved only with documented evidence the pump is medically necessary and that syringe or gravity feedings are not satisfactory due to complications such as aspiration, diarrhea, dumping syndrome, etc.

Medicaid will pay for the rental of a standard enteral infusion pump and accessories. Medicaid can pay for repairs not covered by the warranty or lease agreement.

**Hyperalimentation - Intradialytic Parenteral Nutrition Therapy**

Intradialytic parenteral nutrition therapy (IDPN) is considered for prior authorization (PA) when a gastrointestinal disease or condition is present and is the cause of the beneficiary's inability to sufficiently absorb enough nutrients to maintain their weight and strength. Authorization will not be considered for beneficiaries who only have renal failure or insufficiency and an associated poor appetite or failure to thrive.

Request must include the following information:

1. Documentation that the beneficiary has an inability to sufficiently maintain their weight and strength without the intravenous (IV) nutrition therapy;
2. Documentation that adequate nutrition cannot be made possible by dietary adjustment, oral supplements, or enteral nutrition (tube or non-tube fed); and
3. Documentation that a clinically significant gastrointestinal disease or conditions that have resulted in the beneficiary's malnutrition due to the inability of the

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gastrointestinal (GI) tract to sufficiently absorb enough nutrients. A diagnosis alone is not sufficient to determine coverage.

**Enteral Formula Coverage for Beneficiaries with Inborn Errors of Metabolism**

This policy applies to beneficiaries with known or suspected inborn errors of metabolism served by the Office of Public Health (OPH) Genetic Disease program.

Louisiana Medicaid covers and considers medically necessary enteral formulas for beneficiaries of all ages without PA when the beneficiary has a diagnosis of an inborn error of metabolism made by a physician board certified in medical genetics or an advanced practice registered nurse collaborating with, or a physician assistant supervised by, a physician board certified in medical genetics.

Enteral formulas are also covered and considered medically necessary without PA if a beneficiary is suspected of having an inborn error of metabolism, pending the results of a definitive evaluation, when such enteral formula is needed to prevent morbidity. In this case, the enteral formula does not need to be ordered by a specialist. To provide documentation of medical necessity, the Genetic Disease program must maintain a completed Request for Enteral Formula for Inborn Errors of Metabolism order form in the beneficiary's record which is signed and dated by the appropriate ordering provider. Claims for enteral formula are subject to post-payment review and non-compliance with this policy may result in recoupment of overpayments.