Priority Health	BILLING POLICY No. 073
ENTERAL NUTRITION	
Date of origin: Jan. 3, 2025	**Review dates: 2/2025**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

Enteral nutrition refers to any method of feeding that uses the gastrointestinal tract to deliver nutrition and calories including a normal oral diet, using a liquid supplement or delivery by use of a tube also referred to as a tube feeding (ACG, 2021). Formula for enteral nutrition can be provided by tube feeding or orally, as replacement or supplement to dietary intake. Formula can be standard formula (nutritionally complete with intact nutrients) or Specialized Nutrient Formula. Specialized Nutrient Formulas are used for conditions requiring specific dietary components, requiring the alteration of specific dietary components, or disorders of the carbohydrate, lipid, vitamin, mineral, amino acid or nitrogen metabolism (Greer 2003).

MEDICAL POLICY

Enteral Nutritional Therapy (#91278)

POLICY SPECIFIC INFORMATION

Coding specifics

Supplies, formulae and nutritional solutions associated with enteral services are reported with HCPCS “B” codes.

Enteral nutrition isn’t payable when the member is inpatient at a skilled nursing facility or entity reimbursed for inpatient services. These items and services are inclusive to the inpatient stay.

Enteral feeding supplies

- **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
- **B4148**: Enteral feeding supply kit; elastomeric control fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape

These services include all supplies, other than the feeding tube and nutrients, required for the administration of enteral nutrients to the patient for one day.

Only one unit of service is payable per day.

Supply “kits” defined by codes B4034, B4035, B4036 and B4148 may differ by patient and by date. The supplies for each date are bundled into a supply fee reimbursed as part of the “kit”.

Items included as a component of these codes aren't limited to pre-packaged "kits" bundled by manufacturers or distributors. These supply allowances include, but aren't limited to, a catheter / tube anchoring device, feeding bag / container, flushing solution bag / container, administration set tubing, extension tubing, feeding/flushing syringes, gastrostomy tube holder, dressings (any type) used for gastrostomy tube site, tape (to secure tube or dressings), Y connector, adapter, gastric pressure relief valve, declogging device.

This is not an all-inclusive list.

Supply items aren't separately payable using the miscellaneous code (B9998) or using a specific HCPCS code for any individual item, should a unique HCPCS code for item exist (for example dressing, tape).

The enteral feeding supply kit administration should align to the appropriate administration route. Failure to accurately code the supply kit to an administration route will result in a claim denial. Only one type of kit is payable per day.

Three (3) units of nasogastric tubes are allowed every three months. This may be any combination of B4081, B4082 or B4083.

One (1) unit of gastrostomy or jejunostomy tubes are allowed every three months.

Enteral formula
Enteral formula units are aligned to calories. Example: 1 unit = 100 calories. HCPCS code descriptions with calories identified should align to units supplied in medical documentation.

If two enteral formula or nutrition products are supplied and fall under the same HCPCS code, total units should reflect total calories of products supplied.

HCPCS code B4104 (Additive for enteral formula (e.g., fiber)) isn't separately payable. Enteral formulas are inclusive of all nutrient components such as fiber, vitamins and minerals.

B4105 (In-line cartridge containing digestive enzyme(s) for enteral feeding, each) is reimbursed per date of service.

We don't separately reimburse for the following nutrient or formulas:

- Baby food
- Self-blended formula or products
- Routine formula
- Nutritional supplements (OTC)

Products that are only administered orally should be coded as A9270.

Code B4149 describes formulas containing natural foods that are blended and packaged by a manufacturer. B4149 formulas are classified based upon this manufacturer's requirement, not on the composition of the enteral formula. Code B4149 must not be used for foods that have been blended by the patient or caregiver for administration through a tube.

Documentation requirements

The provider must enter a diagnosis code corresponding to the patient's diagnosis on each claim.

The patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to:

- Duration of the patient's condition
- Clinical course (worsening or improvement)
- Prognosis
- Nature and extent of functional limitations
- Other therapeutic interventions and results
- Past experience with related items, etc.

Information describing the medical necessity for enteral nutrition must be available upon request. To satisfy the test of permanence, there must be documentation to reflect that in the treating practitioner's judgement, the impairment will be of long and indefinite duration.

Documentation in the medical record shall also reflect that the patient has (a) full or partial non-function or disease of the structures that normally permit food to reach the small bowel; or (b) disease that impairs digestion and / or absorption of an oral diet, directly or indirectly, by the small bowel.

Special nutrient formulas – HCPCS codes B4149, B4153, B4154, B4155, B4157, B4161 and B4162 – are produced to meet unique nutrient needs for specific disease conditions. If a special nutrient formula is ordered, the patient's medical records must specify why a standard formula can't be used to meet the patient's metabolic needs. This documentation may include other formulas tried and failed or considered and ruled out. A diagnosis alone isn't sufficient to support the medical need for a specialty formula. For example, an order for a diabetes-specific formula may be supported by documentation in the medical record that the beneficiary has a diagnosis of diabetes mellitus and has experienced severe fluctuations of glucose levels on standard formula.

Modifiers

- **BA modifier**: When an IV pole (E0776) is used for enteral nutrition administered by gravity or a pump, the BA modifier should be added to the code. Code E0776 is the only code with which the BA modifier may be used.
- **BO modifier**: When enteral nutrients (B4149, B4150, B4152, B4153, B4154, B4155, B4157, B4158, B4159, B4160, B4161 and B4162) are administered by mouth, the BO modifier must be added to the code.
- **KX modifier**: Suppliers must add the KX modifier to claim lines billed for enteral nutrition, enteral pump and supplies only if all of the coverage criteria in the "Coverage Indications, Limitations, and/or Medical Necessity" section in the related LCD have been met and evidence of such is retained in the supplier's files and available to the DME MAC upon request. Claim lines billed with codes without a KX modifier will be rejected as missing information.

RESOURCES

- Enteral and Parenteral Nutrition (American College of Gastroenterology)
- American Academy of Pediatrics Committee on Nutrition. Chapter 40 Nutrition in Renal Disease. In: Kleinman RE, Greer FR, eds. Pediatric Nutrition. 8th ed. Itasca, IL: American Academy of Pediatrics; 2019:1123-1150

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added "Disclaimer" section