VERMONT

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The Department of Vermont Health Access Clinical Criteria

Subject: Nutritional Therapy (Enteral Nutrition and Parenteral Nutrition)
Last Review: September 3, 2021*
Past Revisions: June 6, 2019, March 21, 2017; February 4, 2016; January 2, 2015; September 12, 2012; June 28, 2011; June 1, 2004

***Please note: Most current content changes will be highlighted in yellow.**

Description of Service or Procedure

According to the American Society for Parenteral and Enteral Nutrition (ASPEN) (2020):

- Enteral Nutrition is the provision of nutrients via the gastrointestinal (GI) tract through a feeding tube, catheter or stoma. Enteral nutrition is the preferred route for the provision of nutrition for patients who cannot meet their nutritional needs through voluntary oral intake.

- Parenteral Nutrition is a form of nutrition that bypasses the normal digestion in the stomach and bowel. It is a special liquid food mixture given into the blood through an intravenous (IV) catheter (needle in the vein). The mixture contains proteins, carbohydrates (sugars), fats, vitamins and minerals (such as calcium). This special mixture may be called parenteral nutrition and was once called total parenteral nutrition (TPN), or hyper alimentation.

Disclaimer

Coverage is limited to that outlined in Medicaid Rule or Health Care Administrative Rules that pertains to the beneficiary's aid category. Prior Authorization (PA) is only valid if the beneficiary is eligible for the applicable item or service on the date of service.

Medicaid Rule

Medicaid and Health Care Administrative Rules can be found at https://humanservices.vermont.gov/rules-policies/health-care-rules/health-care-administrative-rules-hcar/adopted-rules

7102.2	Prior Authorization Determination
7508.2	Prosthetics Devices Covered Services
4.101	Medical Necessity for Covered Services
4.104	Medicaid Non-Covered Services

Coverage Position

Nutritional support (enteral or parenteral) may be covered for beneficiaries:

- When the device is prescribed by a licensed medical provider, enrolled in the Vermont Medicaid program, operating within their scope of practice as described in their Vermont State Practice Act, who is knowledgeable regarding nutritional support (enteral and/or parenteral), and who provides medical care to the beneficiary AND
- When the clinical criteria below are met.

Coverage Criteria

Nutritional support (enteral or parenteral) may be covered for beneficiaries when:

Enteral

- The beneficiary has a diagnosis for which enteral nutrition products are indicated (i.e.: dysphagia, neuromuscular illness, head and neck cancers, and gastroparesis). **AND**
- There is a functioning gastrointestinal tract. **AND**
- There is pathology or non-function of the structures of the digestive system and the beneficiary cannot maintain weight and strength. **AND**
- The beneficiary has a nasogastric, jejunostomy or gastrostomy tube (selection of appropriate route must take into account the expected duration of treatment, clinical condition of patient and level of consciousness of the patient). **AND**
- The clinical documentation supports need for enteral nutrition (lab measurements demonstrating malnutrition, height, weight, BMI, past treatments and estimated duration of need). **AND**
- The beneficiary has a caregiver who has been trained to provide the feedings OR the beneficiary is able to independently administer the feedings.

Parenteral

- The gastrointestinal tract is nonfunctional or cannot be accessed and the patient cannot be adequately nourished by oral diets or enteral nutrition. **AND**
- The beneficiary has a diagnosis of a disorder or disease process which impairs absorption of sufficient nutrients to preserve weight. **AND**
- Clinical documentation supports need for parenteral nutrition (lab measurements demonstrating malnutrition, height, weight, BMI and past treatments). **AND**
- The beneficiary has a caregiver who has been trained to provide the feedings OR the beneficiary is able to independently administer the feedings.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exception: Vermont Medicaid will provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions for Medicaid members under age 21.

Clinical criteria for repeat service or procedure

Patient must meet criteria listed above.

Type of service or procedure covered

Nutritional Support is covered for low protein modified food products for treatment of an inherited metabolic disease, as required by Act 128 of the 1998 legislative session when it is consistent with the patient's medical condition and plan of care.

Type of service or procedure not covered (this list may not be all inclusive)

Nutritional support is not covered for items or services furnished, paid for, or authorized by an entity of the Federal Government when nutritional support is taken orally i.e. non-medical foods.

References

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