BlueCross BlueShield of Vermont

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Enteral Nutrition
Corporate Medical Policy

File Name: Enteral Nutrition
File Code: 1.02.VT01
Origination: 10/2004
Last Review: 10/2025
Next Review: 10/2026
Effective Date: 03/01/2026

Description/Summary

Enteral Nutrition (EN) is used for patients with a functioning intestinal tract, but with disorders of the pharynx, esophagus, or stomach that prevent nutrients from reaching the absorbing surfaces in the small intestine, thus placing the patient at risk for malnutrition. Enteral nutrition involves the administration of calories, protein, electrolytes, vitamins, minerals, trace elements, and fluids directly into the gastrointestinal tract through nasogastric, gastrostomy or jejunostomy tubes (Tube feedings ONLY). An infusion pump may be used to assist the flow of liquids into the intestinal tract but is not separately billable when formula is required or provided. In the setting of a child or infant requiring solely hydration, the infusion pump and equipment may be billed separately. EN may be administered either intermittently or continuously.

EN may also be used to correct specific nutritional deficiencies.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.
Attachment I- Procedural Code Table & Instructions

When a service may be considered medically necessary

Enteral formula may be medically necessary for treatment in members with an inherited metabolic disease, for members requiring an amino-acid based formula or for members requiring enteral formulas administered through a feeding tube. Such enteral formulas are not typically widely commercially available. Such enteral formulas must be designated to treat a specific metabolic, neurologic, or gastrointestinal condition substantiated by a specialist or subspecialist provider.

NOTE: Refer to Blue Cross VT Corporate Medical Policy Medical Foods for Inherited Metabolic Disease

We cover an infusion pump and necessary equipment for members who require hydration via a feeding tube, even if the member does not require an enteral formula.

Amino-Acid Based Formulas Not Requiring The Use of a Feeding Tube:

Amino-acid based formulas made of 100% free amino acids as the sole protein source are considered **medically necessary** when **ALL** of the following are met:

- Breast milk (if available) and at least two different extensively hydrolyzed infant formulas have not been tolerated;
- The condition was diagnosed by a specialist or subspecialist provider;
- Diagnosis is clinically documented through testing, biopsy, surgical history, or blood in the stool as being one of the following:
  - Immunoglobulin E (IgE) mediated allergies to food proteins
  - Food protein-induced enterocolitis syndrome
  - Eosinophilic disorders
  - Short bowel syndrome
- Interim coverage for up to 90 days may be provided when requested by a physician while actively seeking a diagnosis.

NOTE: 100% pure amino acid formulas may include Neocate, Elecare, Nutramigen AA, PurAmino, and Alfamino. Extensively hydrolyzed formulas may include Nutramigen and Alimentum.

Enteral Feedings Requiring the Use of a Feeding Tube:

Tube feedings are considered **medically necessary** when oral nutrition is prevented by:

- An anatomic or structural disruption that prevents food from reaching the stomach, for example a tumor or stricture of the esophagus or stomach, tracheoesophageal fistula or neck cancer.
- Gastrointestinal disorders, such as disorder of absorption, digestion, utilization, secretion and storage of nutrients.
- Neurological or physiologic disorders that result in a swallowing or chewing problems.
- When there is a diagnosis of failure to thrive or a high risk for becoming malnourished.
- Cardiopulmonary disorders and other conditions of hyper-metabolism such as cancer or burns.
- Malabsorption unresponsive to standard age-appropriate interventions when associated with failure to gain weight or meet established growth expectations.

When medical necessity guidelines for tube feedings are met, benefits are available for the following:

- Nutrients and solution
- Home visits (which may include instruction on catheter care and maintenance) by a registered nurse (RN) or licensed practical nurse (LPN) under the order and supervision of a physician, which meet medical necessity. Rental or purchase of an infusion pump is inclusive to per diem charges.
- If no per diem services are provided, rental or purchase of an infusion pump is separately reimbursable. (Blue Cross VT will not reimburse for equipment rental charges that exceed the purchase price of the equipment).

NOTE: (Instruction in an inpatient setting on catheter care and maintenance is not a separately reimbursable service. (Cannot bill codes 99601 - 99602)

Digestive Enzyme Cartridge:

A digestive enzyme cartridge (for example, Relizorb™) is considered **medically necessary** for use with enteral tube feeding for the treatment of pancreatic insufficiency due to cystic fibrosis when there is documented failure of pancreatic enzyme replacement therapy (PERT.)

When a service is considered not medically necessary

The Plan considers the purchase of nutritional substances for enteral nutrition **not medically necessary** as follows:

- When used primarily to increase protein or calorie intake in addition to the patient's daily diet;
- In patients with stable nutritional status in whom only short-term parenteral nutrition might be required (e.g. less than 2 weeks);
- For routine pre- and/or postoperative care;
- When used in individuals with a feeding tube who are able to take 50% or more of their diet via the oral route;
- Donor breast milk

When a service is considered investigational

A digestive enzyme cartridge (for example, Relizorb™) is considered **investigational** when the above medical necessity criteria are not met and for all other indications.

When a service is considered a benefit exclusion and therefore not covered

Nutritional Formula that falls into the following generally accepted and widely available categories of cow's milk formulas, soy formulas, partially hydrolyzed formulas, casein and whey formulas, AF and fiber fortified formulas, comfort care formulas, standard 22 or 24 kcal/oz formulas, or extensively hydrolyzed formulas are considered a benefit exclusion and therefore are not covered regardless of route. In addition, other over-the-counter formulas

or nutritional supplements and formulas that are routinely stocked for purchase in supermarkets, health food stores, or over the counter at a retail pharmacy, are considered a benefit exclusion and therefore are not covered, regardless of the route of administration or of whether or not they are prescribed by a physician.

Formulas distinguished solely as being organic preparations of the above listed generally accepted and widely available categories of formulas are considered a benefit exclusion and are therefore not covered, regardless of route.

Rare or difficult to obtain formulas which are administered orally are not covered and are considered to be a benefit exclusion with the exception of formulas for Inherited Metabolic Conditions, and 100% Amino Acid formulas which meet the criteria listed above.

Policy Guidelines

Documentation of the inability to tolerate over the counter formulas must be provided to establish medical necessity for special formulas that fall under the descriptions listed for HCPCS codes B4153, B4154, B4155, B4157, B4161, and B4162.

The Plan covers medical foods for enteral nutrition including low protein formula in accordance with Vermont State Mandate if for the medically necessary treatment of certain inherited metabolic diseases and inborn errors of metabolism (IEM), when prescribed by a physician. Please refer to the Blue Cross VT Corporate medical policy on *Medical Food for Inherited Metabolic Diseases* for additional information.

Scientific Background and Reference Resources

Blue Cross Blue Shield Association (BCBSA) Medical Policy Reference Manual. Total Parenteral Nutrition, and Enteral Nutrition in the Home, Issue 1:2003, Archived June 2009.

Blue Cross and Blue Shield of Massachusetts Home TPN policy dated 1/16/06, Wellmark Home Total Parenteral Nutrition Policy dated June 2005.

ASPEN. American Society for Parenteral and Enteral Nutrition Board of Directors. Standards of Practice for Home Nutrition Support. *Journal of Parenteral and Enteral Nutrition, Volume 33, Number 2, March/April 2009 122-167*

The following website is useful to determine which products are assigned to a specific HCPCS code: https://www.dmepdac.com/

1. Haddad RY, Thomas DR. Enteral nutrition and enteral tube feeding. Review of the evidence. Clin Geriatr Med. 2002; 18(4):867-881.
2. Høst A, Koletzko B, Dreborg S, et al. Dietary products used in infants for treatment & prevention of food allergy. Joint Statement of the European Society for Paediatric Allergology and Clinical Immunology (ESPACI) Committee on Hypoallergenic Formulas and the European Society for Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) Committee on Nutrition. Arch Dis Child. 1999; 81(1):80-84.
3. Joly F, Dray X, Corcos O, et al. Tube feeding improves intestinal absorption in short

bowel syndrome patients. Gastroenterology. 2009; 136(3):824-831.
4. Klek S, Hermanowicz A, Dziwiszek G, et al. Home enteral nutrition reduces complications, length of stay, and health care costs: results from a multicenter study. Am J Clin Nutr. 2014; 100(2):609-615.
5. Nakajoh K, Nakagawa T, Sekizawa K, et al. Relation between incidence of pneumonia and protective reflexes in post-stroke patients with oral or tube feeding. J Intern Med. 2000; 247(1):39-42.
6. Riva E, Fiocchi A, Fiori L, Giovannini M. Prevention and treatment of cow's milk allergy. Arch Dis Child. 2001; 84(1):91.
7. Schwenk WF 2nd. Specialized nutrition support: the pediatric perspective. JPEN J Parenter Enteral Nutr. 2003; 27(3):160-167, viii.
8. Freedman S, Orenstein D, Black P, Brown P, McCoy K, Stevens J, Grujic D, Clayton R. Increased Fat Absorption From Enteral Formula Through an In-line Digestive Cartridge in Patients With Cystic Fibrosis. J Pediatr Gastroenterol Nutr. 2017 Jul;65(1):97-101. doi: 10.1097/MPG.0000000000001617. PMID: 28471913.
9. Alcresta Therapeutics. https://www.relizorb.com. Accessed October 2022.

Related Policies

Home Infusion Therapy
Total Parenteral Nutrition (TPN) in the Home Setting
Medical Food for Inherited Metabolic Disease
CPP_14 Home Infusion Therapy (Including enteral nutrition and total parenteral nutrition) Payment Policy

Document Precedence

Blue Cross and Blue Shield of Vermont (Blue Cross VT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, Blue Cross VT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, Blue Cross VT reserves the right to recoup all non- compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval may be required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

10/2004	New Policy
03/2005	Billing codes updated
05/2006	Minor language changes and additional medical necessity criteria added
06/2007	Code description added- Reviewed by the CAC 09/2007
08/2011	Policy separated from BCBSVT medical policy on Total Parenteral Nutrition and Enteral Nutrition; language added concerning non-coverage of teaching in the hospital setting, language clarification on non-coverage of over-the-counter nutritional supplements; HCPCS coding descriptions updated and non-covered code section added. Codes reviewed and approved by Medical/Clinical Coder SAF
01/2013	Updated CPT code listing attachment
11/2014	Updated CPT code listing attachments I and II
06/2015	Per diem language added. Codes B4158, B4159 and B4160 non-covered. KAF.
05/2016	Durable medical equipment providers added back to policy as eligible providers.

05/2017	Clarified when service may be medically necessary; updated related policies; removed HCPCS code B9000 was deleted 1/1/2017 with no replacement, B9002 corrected, B9998 clarified description; policy statement remains unchanged.
06/2019	Updated policy with medical necessity criteria for 100% Amino Acid formulas. B4105 new code effective 01/01/2019. Codes B9002 & B9998 require prior approval.
09/2020	Removed the language regarding a prescription, as it is no longer applicable
11/2020	Added related policy: BCBSVT Payment Policy Home Infusion CPP_14 to related policy section of policy.
07/2021	Updated policy statement to clarify essentially that amino-acid based formulas do not need to be administered via a feeding tube to be medically necessary. Also, clarified policy statement infusion pump and necessary equipment for children and infants <18 years of age who require hydration via a feeding tube, even if the child does not require an enteral formula. Added under not medically necessary doner breast milk.
10/2022	Policy reviewed. Addition of policy criteria for Digestive Enzyme Cartridge. B4105 requires prior approval. Minor formatting changes. References updated. Updated related policy section. External feedback received.
09/2023	Policy Reviewed. Removed reference to age in medical necessity criteria. Added code B4148 to coding table as requiring prior approval.
10/2024	Policy reviewed. Removed criteria language around age requirements. Minor formatting changes for clarity and consistency. Updated coding table with the following changes: Removed codes from prior approval B4034, B4035, B4081, B4082, B4083, B4087, B4088, B4105, B4148, B4162, B9002, B9998, S9340, S9341, S9342, S9343. Code B9998 will suspend for medical review.
10/2025	Policy Reviewed. Removed language “In the category of personal service, comfort or convenience items including formulas and supplements described by HCPCS codes B4100, B4102-B4104; B4149-B4152, B4158 - B4160.” Minor formatting changes for consistency.

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on Blue Cross VT requirements for billing of NDC please refer to the provider portal https://www.bluecrossvt.org/providers latest news and communications.

Eligible Providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by Blue Cross VT Medical Directors

Tom Weigel, MD, MBA
Vice President and Chief Medical Officer

Tammaji P. Kulkarni, MD
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Attachment I
Procedural Code Table & Instructions

Code Type	Number	Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
HCPCS	B4034	Enteral feeding supply kit; syringe fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape	
HCPCS	B4035	Enteral feeding supply kit; pump fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape	
HCPCS	B4036	Enteral feeding supply kit; gravity fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape	Prior Approval Required
HCPCS	B4081	Nasogastric tubing with stylet	
HCPCS	B4082	Nasogastric tubing without stylet	
HCPCS	B4083	Stomach tube - levine type	
HCPCS	B4087	Gastrostomy/jejunostomy tube, standard, any material, any type, each	

Code Type	Number	Description	Policy Instructions
HCPCS	B4088	Gastrostomy/jejunostomy tube, low-profile, any material, any type, each	
HCPCS	B4105	In-line cartridge containing digestive enzyme(s) for enteral feeding, each	
HCPCS	B4148	"Enteral feeding supply kit; elastomeric control fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape"	
HCPCS	B4153	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Prior Approval Required
HCPCS	B4154	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Prior Approval Required
HCPCS	B4155	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g. glucose polymers), proteins/amino acids (e.g. glutamine, arginine), fat (e.g. medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit	Prior Approval Required

Code Type	Number	Description	Policy Instructions
HCPCS	B4157	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Prior Approval Required
HCPCS	B4161	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Prior Approval Required
HCPCS	B4162	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
HCPCS	B9002	Enteral nutrition infusion pump, any type	
HCPCS	B9998	Not otherwise classified for enteral supplies	Suspend for Medical Review
HCPCS	S9340	Home therapy; enteral nutrition; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	
HCPCS	S9341	Home therapy; enteral nutrition via gravity; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	

Code Type	Number	Description	Policy Instructions
HCPCS	S9342	Home therapy; enteral nutrition via pump; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	
HCPCS	S9343	Home therapy; enteral nutrition via bolus; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	
Modifier	-BA	Item furnished in conjunction with parenteral enteral nutritional (PEN) services	Append HCPCS modifier on claim form to indicate administered via tube feeding.
Modifier	-BO	Orally administered nutrition, not by feeding tube	Append HCPCS modifier on claim form to indicate that supply is being taken orally. *Not medically necessary unless billed with a diagnosis for inherited metabolic disease. See separate medical policy for details.
The following codes are considered benefit exclusions and therefore Non-Covered.			
HCPCS	B4100	Food thickener, administered orally, per ounce	Benefit Exclusion
HCPCS	B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit	Benefit Exclusion
HCPCS	B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit	Benefit Exclusion
HCPCS	B4104	Additive for enteral formula (e.g. fiber)	Benefit Exclusion

Code Type	Number	Description	Policy Instructions
HCPCS	B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Benefit Exclusion
HCPCS	B4150	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Benefit Exclusion
HCPCS	B4152	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Benefit Exclusion
HCPCS	B4158	Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit	Benefit Exclusion
HCPCS	B4159	Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit	Benefit Exclusion

Code Type	Number	Description	Policy Instructions
HCPCS	B4160	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Benefit Exclusion