

Enteral nutrition

Blue Care Network provides coverage for this procedure for pediatric (over the age of 1) and adult members who meet medical necessity criteria. Submit authorization requests through e-referral.

The submitter will receive a prompt to complete a questionnaire to determine the appropriateness of the requested service. The questions are listed below.

If all questions are answered, e-referral will either approve or pend the case. If the case pends and BCN cannot authorize it, BCN will contact the provider for additional clinical information. Authorization is not a guarantee of payment.

Payment is based on established claim edits. Compliance with this prior authorization requirement will be monitored retrospectively.

Applicable codes: B4034, B4035, B4036, B4081, B4082, B4083, B4087, B4088, B4102, B4103, B4104, B4105, B4149, B4150, B4152, B4153, B4154, B4155, B4157, B4158, B4159, B4160, B4161, B4162, B9002, B9998, S9341, S9342, S9343

See below for the questions you'll encounter for this procedure in the e-referral system.

You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

Q Does the patient require enteral nutrition by TUBE FEEDINGS to provide sufficient nutrients to maintain weight and strength in proportion with the patient's overall health status due to a EITHER A or B? A. Dysfunction of indefinite duration or disease of the structures that normally permit food to reach the small bowel B. Disease of the small bowel that impairs digestion and absorption of an oral diet

A Possible answers: Yes No N/A

Q Is the patient's condition of long and indefinite duration (ordinarily at least three months)?

A Possible answers: Yes No N/A

Q Does the patient's medical record include ALL of the following (all A-D)? A. The patient's general condition, including age, height and weight, estimated duration of therapy, ambulatory status and mental status B. The patient's condition is either anatomic or due to a motility disorder C. A clinical assessment of the patient with an evaluation of nutrition, albumin, transferrin, hematocrit, clinical findings, etc. within 30 days prior to certifying or re-certifying the need for the enteral nutrition D. The patient's nutritional prescription (including but not limited to): Name of the nutrient, number of calories per day (100 calories = 1 unit), frequency/day, method (syringe, gravity or pump), route (nasogastric tube, gastrostomy tube), rationale for pump, if necessary, attending physician's signature

A Possible answers: Yes No N/A

See below for the questions you'll encounter for this procedure in the e-referral system. (continued)

You must answer each question by choosing either Yes, No, Not Applicable or another appropriate option.

Q Does the patient have a functioning gastrointestinal tract whose need for enteral nutrition is due to reasons such as anorexia or nausea associated with mood disorder, end-stage disease? Note: must select NO if member does not have one of these conditions.

A Possible answers: Yes No

Q Can the patient's nutrition be adequately met by dietary adjustment and/or oral supplements?

A Possible answers: Yes No

Q Are the enteral nutrition products and the related supplies being administered orally?

A Possible answers: Yes No

Q Is the request for food thickeners, baby food, infant formulas and other regular grocery products which are being used in conjunction with oral or enteral feedings?

A Possible answers: Yes No

Q Are a feeding pump and supplies being requested, AND gravity feeding is not satisfactory due to the patient having a condition such as aspiration, diarrhea or dumping syndrome? Note: MUST select N/A if a feeding pump is NOT required.

A Possible answers: Yes No N/A