MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

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Subject: New HCPCS Procedure Codes for Enteral and Parenteral Nutrition
New Parameters for Coverage Without Prior Authorization
Medical Criteria for Coverage of Enteral and Parenteral Nutrition

Effective: February 1, 2002

Programs Affected: Medicaid and Children's Special Health Care Services

New HCPCS Procedure Codes for Enteral and Parenteral Nutrition

Effective for dates of service on and after February 1, 2002, many of the Michigan Medicaid local procedure codes for enteral nutrition (introduced by tube) and parenteral nutrition will be replaced with the national standard Health Care Financing Administration Common Procedure Coding System (HCPCS). Prior authorization (PA) will no longer be required for selected procedure codes and parameters. For claims that fall outside these parameters, PA will still be necessary. Please refer to the attached tables provided in this bulletin for the following information:

- **Table 1** HCPCS procedure codes and parameters for enteral nutrition (administered as tube feedings)
- **Table 2** Michigan Medicaid local codes for enteral nutrition retained by the program
- **Table 3** New categories for approved and non-approved enteral formulae (administered as tube feedings)
- **Table 4** HCPCS procedure codes and parameters for parenteral nutrition.
- **Table 5** International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) diagnosis codes for exception to the PA process for parenteral nutrition.

New Parameters for Coverage Without Prior Authorization

Prior authorization will no longer be required for the following:

- Standard formula for **enteral tube feedings** provided up to the program's established quantity limits per month. (Applies to enteral formulae codes B4150 and B4152 **only** and related supplies and equipment)
- Parenteral nutrition administered for specific medical conditions as defined in **Table 5.** (Applies to parenteral solutions, related supplies and equipment)

Prior authorization will remain a requirement for the following:

- All enteral formula requests for oral feedings. (Applies to Michigan Medicaid local codes Y3810 and Y3812)
- All specialized enteral formula requests for both tube and oral feedings
- Over-quantity requests for standard formulae enteral tube feedings
- Parenteral nutrition (for medical conditions other than diagnosis exception codes listed in Table 5).

Documentation Requirements for Enteral and Parenteral Nutrition

Documentation of medical necessity for all enteral and parenteral nutrition must include a current prescription and/or Certificate of Medical Necessity (CMN) with a diagnosis appropriate for the specified treatment. This documentation must be kept in the beneficiary's file and retained by the medical supplier.

Documentation to support coverage must include the following:

- Specific diagnosis related to the beneficiary's inability to take or eat regular food
- For oral feedings, list economic alternatives that have been tried. For beneficiaries 21 and over, also list laboratory values for albumin or total protein.
- Amount needed per day
- Duration of treatment
- Height, current weight, and recent weight loss
- Specific prescription identifying levels of individual nutrient(s) that is required in increased or restricted amounts.

If the procedure code requires prior authorization, a copy of the above documentation must be submitted with the PA request form.

TABLE 1 – Enteral Nutrition (Administered By Tube) - HCPCS Procedure Codes and Parameters

Enteral Formulae

Nomenclature	HCPCS Procedure Code	Modifier	Maximum Quantity	Remarks
ENTERAL FORMULAE; CATEGORY I; SEMI – SYNTHETIC INTACT PROTEIN/PROTEIN ISOLATES, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	B4150		900 units per month	Replaces Y3803
ENTERAL FORMULAE; CATEGORY I; NATURAL INTACT PROTEIN/PROTEIN ISOLATES, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	B4151			Replaces Y3802

Nomenclature	HCPCS Procedure Code	Modifier	Maximum Quantity	Remarks
ENTERAL FORMULAE, CATEGORY II; INTACT PROTEIN/PROTEIN ISOLATES (CALORICALLY DENSE), ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	B4152		900 units per month	Replaces Y3803
ENTERAL FORMULAE; CATEGORY III: HYDROLIZED PROTEIN/AMINO ACIDS, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	B4153			Replaces Y3802 Prior authorization is required
ENTERAL FORMULAE; CATEGORY IV: DEFINED FORMULA FOR SPECIAL METABOLIC NEED, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	B4154			Replaces Y3802 Prior authorization is required
ENTERAL FORMULAE; CATEGORY V: MODULAR COMPONENT (PROTEIN, CARBOHYDRATES, FAT), ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	B4155			Replaces Y3802 Prior authorization is required
ENTERAL FORMULAE; CATEGORY VI: STANDARDIZED NUTRIENTS, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	B4156			Replaces Y3802 Prior authorization is required

Equipment and Supplies

Nomenclature	HCPCS Procedure Code	Modifier	Maximum Quantity	Remarks
INDWELLING CATHETER; FOLEY TYPE, TWO-WAY LATEX WITH COATING (TEFLON, SILICONE, SILICONE ELASTOMER, OR HYDROPHILIC, ETC.), EACH	A4338		2 per month	Replaces Y3720
INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, ALL SILICONE, EACH	A4344		2 per month	Replaces Y3720

Nomenclature	HCPCS Procedure Code	Modifier	Maximum Quantity	Remarks
ENTERAL FEEDING SUPPLY KIT; SYRINGE, PER DAY	B4034		30 per month	Use for Bolus/Syringe Fed Only
ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY	B4035		30 per month	Replaces Y3719
ENTERAL FEEDING SUPPLY KIT; GRAVITY FED, PER DAY	B4036		30 per month	Replaces Y3715
NASOGASTRIC TUBING WITH STYLET	B4081		5 per month	
NASOGASTRIC TUBING WITHOUT STYLET	B4082		5 per month	
STOMACH TUBE – LEVINE TYPE	B4083		30 per month	
GASTROSTOMY/ JEJUNOSTOMY TUBING	B4084		4 per month	
GASTROSTOMY TUBE, SILICONE WITH SLIDING RING, EACH	B4085		1 per month	
ENTERAL NUTRITION INFUSION PUMP – WITHOUT ALARM	B9000	RR	1 per month	10 months = purchase
ENTERAL NUTRITION INFUSION PUMP – WITH ALARM	B9002	RR	1 per month	10 months = purchase
NOC FOR ENTERAL SUPPLIES	B9998			Prior authorization is required
IV POLE	E0776	RR	1 per month	10 months = purchase

TABLE 2 – Michigan Medicaid Local Codes With No Current HCPCS Comparisons

Supplies and Enteral Formulae Administered Orally

Nomenclature	Michigan Medicaid Procedure Code	Modifier	Maximum Quantity	Remarks
LOW PROFILE GASTROSTOMY KIT	Y3120		3 per 6 months	
LOW PROFILE GASTROSTOMY TUBING KIT, I.E., EXTENSION SETS, DECOMPRESSION, BOLUS, ETC.	Y3121		12 per month	
CLEFT PALATE NURSERS, EACH	Y3722		4 per month	
LONG TERM REPLACEMENT FEEDING CATHETER, E.G., GASTROSTOMY BUTTON, EACH	Y3733		3 per 6 months	

Nomenclature	Michigan Medicaid Procedure Code	Modifier	Maximum Quantity	Remarks
FEEDING TUBE FOR LONG TERM REPLACEMENT FEEDING CATHETER, EACH	Y3734		6 per month	
FORMULAE ADMINISTERED ORALLY; STANDARD LIQUID FORMULA FOR MEAL REPLACEMENT OR SUPPLEMENTATION, E.G., ENSURE, SUSTACAL, 100 CALORIES = 1 UNIT	Y3810			Prior authorization is required
FORMULAE ADMINISTERED ORALLY; FORMULA WITH UNIQUE COMPOSITION OR INGREDIENTS NOT ORDINARILY AVAILABLE FROM REGULAR FOOD, E.G., POLYCOSE, M.C.T., OIL, VIVONEX, 100 CALORIES = 1 UNIT	Y3812			Prior authorization is required

Medical Criteria for Coverage of Enteral Nutrition

Enteral Nutrition

Enteral nutrition is the nutrition administered by tube or orally into the gastrointestinal tract.

Dietary formulae for oral feedings may be obtained from either a medical supplier (Provider Type 87) or a pharmacy (Provider Type 50). Oral feed formulae are covered in limited circumstances when the beneficiary is temporarily unable to eat.

Coverage for enteral nutrition (administered orally) is considered for CSHCS and Medicaid beneficiaries when **both** of the following conditions apply:

1) The unique composition of the formula contains nutrients the beneficiary is unable to obtain from food.

2) The nutritional composition of the formula represents an integral part of treatment of the specified diagnosis/condition.

Supplementation to regular diet or meal replacement is only considered if there is failure to thrive when the beneficiary's weight to height ratio has fallen below the 5th percentile on standard growth grids. This would apply to beneficiaries under the age of 21 only. Mechanical or physiological conditions precluding normal dietary intake are taken into consideration for coverage as well as temporary medical complications necessitating a short-term (less than two months) use of the formula. However, coverage to accommodate psychological or behavioral conditions, food preferences, allergies, loss of appetite, or non-compliance with a specialized diet would not be a consideration.

Enteral nutrition introduced by tube, may be administered by syringe, gravity, or pump. This type of dietary formula is covered by the CSHCS and Medicaid Program only through the medical supplier (Provider Type 87). Some patients may experience complications associated with the syringe or gravity method of administration. Therefore, if a pump is ordered instead, there must be documentation to justify its use. The documentation of medical necessity must include a current prescription and/or Certificate of Medical Necessity (CMN) with a diagnosis appropriate for the specified treatment. This documentation must be kept in the beneficiary's file and retained by the medical supplier. The feeding supply kit billed to the program must correspond to the method of administration requested.

Billing Guidelines

When billing for enteral formulae (administered orally or by tube), the appropriate formula procedure code should be billed on a monthly basis with total calories used (divided by 100) as the unit amount. If billing both B4150 and B4152, then the combined quantity limit would be 900 units without PA. The necessary equipment and supply code for enteral tube feedings should be billed up to specified quantity limits. It is understood that feeding bags, syringes, dressings, tape, adaptors, tube anchoring devices and connectors used in conjunction with a gastrostomy or enterostomy tube are included in one of the supply kit codes (B4034 – B4036) and should not be billed separately.

For Medicaid and CSHCS beneficiaries residing within a long-term care facility, enteral formula (introduced orally or by tube) and supplies are considered part of their per diem rate.

New Categories for Approved and Non-Approved Enteral Formulae (Administered by Tube)

Seven enteral formula HCPCS categories have been defined for tube feedings. The enteral formula products that are listed under each main category possess similar characteristics and are priced as similar products. Nevertheless, each list is not all-inclusive nor are all the enteral formulae generically equivalent within a specific category. The categories are provided as a guideline for medical suppliers when the prescriber has ordered an enteral formula using the brand name. For products not listed below, providers may contact the Statistical Analysis DME Regional Carrier (SADMERC) for a coding determination or refer to the Enteral Product Classfication List on the SADMERC web site at www.palmettogba.com. If none of the classifications are appropriate, the not otherwise classified code (NOC) of B9998 should be used. To calculate the appropriate number of caloric units per code, divide the number of calories per can by 100. Medicaid will reimburse for up to 900 units for codes B4150 or B4152 without prior authorization.

TABLE 3 – Categories for Approved and Non-Approved Enteral Formulae

CODE B4150 – SEMI-SYNTHETIC INTACT PROTEIN (STANDARD FORMULA < 3.5 units/8 oz.)			
Attain	Fibersource	Nitrolan	Promote
Bio-care (powder)	Fibersource HN	NuBasics VHP	Propac Powder
Boost	Glytrol	Nutramigen	Resource
Boost High Protein Liquid	Isocal	Nutren 1	Resource for Kids w/Fiber
Boost High Protein Powder	Isocal HN	Nutrilan	Resource Diabetic
Boost w/Fiber	Isocal HN Plus	Osmolite	Resource for Kids
Citrisource	Isolan	Osmolite HN	Sustacal
Enlive	Isosource	Osmolite HN Plus	Sustacal w/Fiber
Ensure	Isosource HN	Pediasure	Sustagen Powder
Ensure High Protein	Jevity	Pediasure w/ Fiber	Ultracal
Ensure HN	Jevity Plus	Portagen Powder	Ultracal HN Plus
Ensure w/ Fiber	Kindercal	ProBalance	
Fiberlan	Lonalac Powder	Profiber Liquid	

CODE B4151– NATURAL INTACT PROTEIN/PROTEIN ISOLATES SPECIALIZED FORMULA - PRICED BY REPORT		
Compleat Modified	Compleat-B	Vitaneed

CODE B4152– INTACT PROTEIN/PROTEIN ISOLATES (CALORICALLY DENSE) (STANDARD FORMULA > 3.5 units/8 oz.)			
Boost Plus	Isosource 1.5	NutrAssist 1.5	Sustacal Plus
Comply	Magnacal	Nutren 1.5	TwoCal HN
Deliver 2.0	NovaSource 2.0	Nutren 2.0	Ultralan
Ensure Plus	NuBasics Plus	Resource Plus	
Ensure Plus HN	NuBasics 2.0	Respalor	

CODE B4153 – HYDROLIZED PROTEIN/AMINO ACIDS SPECIALIZED FORMULA - PRICED BY REPORT			
Criticare HN	Neocate	Peptamen 1.5 Diet	Vital HN
Glutasorb RTU	Neocate One Liquid	Peptical	Vivonex Pediatric
Isotein HN Powder	Neocate One Powder	Reabilan	Vivonex TEN
L-Emental	NutriVir	Subdue	
L-Emental Pediatric	Optimental	Travasorb HN	

CODE B4154– DEFINED FORMULAE FOR SPECIAL METABOLIC NEED SPECIALIZED FORMULA - PRICED BY REPORT/ONE CALORIC UNIT			
Acerflex	Isosource VHN	Peptamen	Renalcal
Advera	L-Emental Hepatic	Peptamen Jr	Re-Neph
Alimentum	Lipisorb Liquid	Peptamen VHP	Re-Neph Free
Alitraq Powder	Lipisorb Powder	Perative	Replete
Amin Aid Powder	Lofenelac Powder	Periflex (powder)	Resource Select
Analog (All Types)	Magnacal Renal	Phenex 1	Sandosource Peptide
Choice DM	Maxamaid (All Types)	Phenex 2	Stresstein Powder
Citrotein Powder	Maxamum (All Types)	PhenyAde Powder	Suplena (Replena)
Cyclinex-1	MSUD Diet Powder	Phenylfree Powder	Traumacal
Cyclinex-2	MSUD Maxamum	PKU 1, 2, and 3	Traum-Aid HBC
Diabetisource	MSUD-1 Powder	Pregestimil	Travasorb Hepatic
Duocal	MSUD-2 Powder	Pro-Peptide	Travasorb -MCT
EleCare Powder	Nepro	Pro-Peptide VHN	Travasorb Renal
Elemental 028 Extra	NovaSource Pulmonary	Propimex 1 (powder)	Vivonex Plus
Glucerna	Novasource Renal	Propimex 2 (powder)	
Glucerna OS	Nutrihep	Protein Free Powder 80056	
Hepatic-Aid Powder	NutriVent	Pulmocare	
Immun-Aid	OS 1	Reabilan-HN	
Impact	OS 2	ReGain Plus	

CODE B4155– MODULAR COMPONENTS SPECIALIZED FORMULA - PRICED BY REPORT/ONE CALORIC UNIT			
Casec Powder	Juven	Phlexy-10 Drink Mix	Propac Powder
Essential Pro Plus	Lipomul	Polycose Liquid	ReSource Inst Protein Powder
Gevral Protein Powder	MCT Oil	Polycose Powder	Ross Carbohydrate Free (RCF)
Hom 2	Microlipid	ProCel Powder	Sumacal
HPF Plus	Moducal Powder	Product 3232A	
Immunocal	Phlexy-10 Capsules	ProMod Powder	

CODE B4156– STANDARDIZED NUTRIENTS SPECIALIZED FORMULA - PRICED BY REPORT/ONE CALORIC UNIT		
Tolerex Powder	Travasorb STD	

NON-COVERED ITEMS		
Standard Infant/Toddler Formulae	Weight Loss Products	Regular and Special Dietetic Foods
Puddings/Bars	Liquid Thickeners	Sports Drinks

Non-Covered Items

This category represents products that are non-covered. Examples of these products are as follows:

- Standard infant/toddler formulae
- Weight loss products or “lite” products
- Regular and special dietetic foods or those formulae representing only a liquid form of food
- Puddings/bars
- Liquid Thickeners
- Sports Drinks

TABLE 4 – Parenteral Nutrition –HCPCS Procedure Codes and Parameters

Parenteral Solutions

Nomenclature	HCPCS Procedure Code	Modifier	Maximum Quantity	Remarks
PARENTERAL NUTRITION SOLUTION, LIPIDS, 10% WITH ADMINISTRATION SET (500 ML = 1 UNIT)	B4184		30 per month	Prior authorization required except for specified diagnoses (555.0, 560.9, 569.81, 577.0, 577.1, 577.2, 579.3)
PARENTERAL NUTRITION SOLUTION, LIPIDS, 20% WITH ADMINISTRATION SET (500 ML = 1 UNIT)	B4186		30 per month	Prior authorization required except for specified diagnoses (555.0, 560.9, 569.81, 577.0, 577.1, 577.2, 579.3)
PARENTERAL NUTRITION SOLUTION; COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, 10 TO 73 GRAMS OF PROTEIN - PREMIX	B4189		30 per month	Prior authorization required except for specified diagnoses (555.0, 560.9, 569.81, 577.0, 577.1, 577.2, 579.3)
PARENTERAL NUTRITION SOLUTION; COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, 52 TO 73 GRAMS OF PROTEIN - PREMIX	B4193		30 per month	Prior authorization required except for specified diagnoses (555.0, 560.9, 569.81, 577.0, 577.1, 577.2, 579.3)

Nomenclature	HCPCS Procedure Code	Modifier	Maximum Quantity	Remarks
PARENTERAL NUTRITION SOLUTION; COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, 74 TO 100 GRAMS OF PROTEIN - PREMIX	B4197		30 per month	Prior authorization required except for specified diagnoses (555.0, 560.9, 569.81, 577.0, 577.1, 577.2, 579.3)

Equipment and Supplies

Nomenclature	HCPCS Procedure Code	Modifier	Maximum Quantity	Remarks
PARENTERAL NUTRITION SUPPLY KIT; PREMIX, PER DAY	B4220		30 per month	
PARENTERAL NUTRITION ADMINISTRATION KIT, PER DAY	B4224		30 per month	
PARENTERAL NUTRITION INFUSION PUMP, PORTABLE	B9004	RR	30 per month	
PARENTERAL NUTRITION INFUSION PUMP, STATIONARY	B9006	RR	30 per month	
NOC FOR PARENTERAL SUPPLIES	B9999			Prior authorization is required

Medical Criteria for Coverage of Parenteral Nutrition

Parenteral nutrition is the provision of nutrients intravenously. Its coverage must be related to an impairment or disease of the gastrointestinal track that impairs the ability of nutrients to be digested and absorbed. **Table 5** indicates the diagnosis exception codes for which prior authorization will no longer be necessary for the parenteral solutions and related equipment and supplies:

TABLE 5 - ICD-9 Specified Diagnosis Exception Codes

Diagnosis Code	Description
555.0	Noninfectious enteritis of the small intestine
560.9	Unspecified intestinal obstruction
569.81	Fistula of intestine, excluding rectum and anus
577.0	Acute pancreatitis
577.1	Chronic pancreatitis
577.2	Cyst and pseudocyst of pancreas
579.3	Other and unspecified postsurgical nonabsorption**

**Medical documentation must support one of the following conditions:

- Recent massive small bowel resection leaving less than five feet of small bowel remaining beyond the ligament of Treitz (or)
- Short bowel syndrome with severity that involves a net gastrointestinal fluid and electolyte malabsorption in which the enteral losses exceed 50% of oral/enteral intake.

For Medicaid beneficiaries residing within a long-term care facility, the parenteral solution, equipment and supplies may be billed by the appropriate ancillary provider (e.g., medical supplier, durable medical equipment supplier).

Billing Guidelines

Parenteral nutrition must be billed as a daily rate by reporting total number of days used as units. The parenteral lipids (B4184 or B4186), the parenteral pre-mix solution (B4189, B4193 or B4197), the infusion pump (B9004 or B9006), supply kit (B4220), and the administration kit (B4224) may be billed in combination with each other in place of the all-inclusive code B9999. If reporting parenteral lipids (B4184 or B4186) without one of the parenteral pre-mix solutions, only the pump code would be separately reimbursed. It is understood that the administration kit would include the extension sets, pump cassettes, clamps, containers, and connectors. The supply kit includes all necessary medical supplies such as dressings, tape, alcohol wipes, filters, syringes, needles, and injection caps.

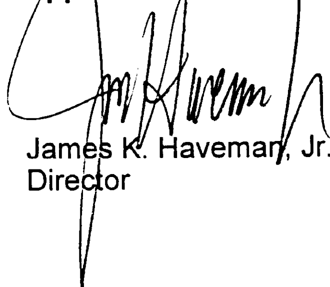
Manual Maintenance

Retain this bulletin for future reference.

Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@state.mi.us. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approved



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