Clinical Policy: Enteral Nutritional Supplements

Reference Number: OR.CP.PMN.1017
Effective Date: 02.01.26
Last Review Date: 02.26
Line of Business: Medicaid – Trillium Oregon Health Plan Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Enteral nutrition (EN) refers to nutritional formula administered by tube or orally fed into the gastrointestinal tract through oral intake or tube feeding when oral intake alone is insufficient or not possible. EN is indicated for patients with a functional GI tract who are unable to meet their nutritional requirements through regular diet due to illness, injury, or medical treatment. It includes the administration of complete or supplemental formulas designed to provide macronutrients, micronutrients, and fluids necessary for maintaining or improving nutritional status. EN is preferred over parenteral nutrition whenever feasible, as it supports gut integrity, reduces infection risk, and is generally associated with improved clinical outcomes.

**This policy applies to requests for coverage through Pharmacy benefit. When billed correctly with HCPCS codes, through member's Medical coverage, enterally given supplements, enterally administered nutritional formulas and oral thickeners do not require prior authorization (PA).*

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Trillium Community Health Plan that enteral nutritional supplements are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. All Indications (must meet all)**:**

1. Member meets one of the following (a, b, c or d):
   a. Diagnosis of chronic and permanent illness/trauma resulting in inability to be maintained through oral feeding and must rely on enteral/parenteral nutrition therapy. (i.e., permanent enteral/parenteral prosthetic device is required);
   b. Documentation of functioning GI tract who, due to pathology to, or non-function of, the structures that normally permit food to reach the digestive tract (oral feeding), cannot maintain weight and strength commensurate with his/her general condition. (ex. head/neck cancer with reconstructive surgery and CNS disease leading to interference with the neuromuscular mechanism);
   c. Documentation of use for training in the ketogenic diet for children with epilepsy in cases where the child has failed or not tolerated conventional therapy;
   d. Enteral access device (tube) is required to provide sufficient nutrients to maintain weight and strength otherwise not possible by dietary adjustments and/or oral supplements

Approval duration: 12 months

II. Continued Therapy

A. All Indications (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Documentation of an annual assessment by a registered dietitian (RD) or treating practitioner recommending continued use of nutritional supplementation;

Approval duration: 12 months

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 for Medicaid or evidence of coverage documents;

IV. Dosage and Administration

Varies by product

V. Product Availability

Varies by product

VI. References

1. Oregon Administrative Rule 410-148-0260 Home Enteral Nutrition. Oregon Health Authority. Health Systems Division: Medical Assistance Programs - Chapter 410, Division 148 HOME ENTERAL/PARENTERAL NUTRITION AND IV SERVICES. Available at: https://secure.sos.state.or.us. Accessed January 13, 2026.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01.13.26	02.17.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.